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ABSTRACT

Intended to inform policymaking in the public and private sectors, this booklet compiles secondary data for 55 health status indicators. The book provides both graphical and textual summaries of data, and addresses long-term trends where applicable. Data are presented for the target populations of Title V funding: infants, children, adolescents, and women of childbearing age. In addition to health status, the book addresses health services utilization and population characteristics. Following the introduction, which discusses trends and issues in children's health, the booklet has six sections: (1) "Population Characteristics," including children in poverty, maternal age, working mothers, and school dropouts; (2) "Health Status," discussing the health issues related to infants, children, and adolescents; (3) "Health Services and Utilization," including health care financing, vaccination coverage levels, physician visits, service utilization by children with chronic conditions, hospital utilization, and prenatal care; (4) "State-Specific Data," including data tables on infant and neonatal mortality, prenatal care, low birth weight, births to women under 18, Medicaid information, and health care financing; (5) "City Data," focusing on comparisons between cities with populations over 100,000 and national data on infant mortality, low birth weight, and prenatal care; and (6) "Progress towards Healthy People 2000," summarizing progress toward several prevention objectives. (Contains 34 references.) (HTH)

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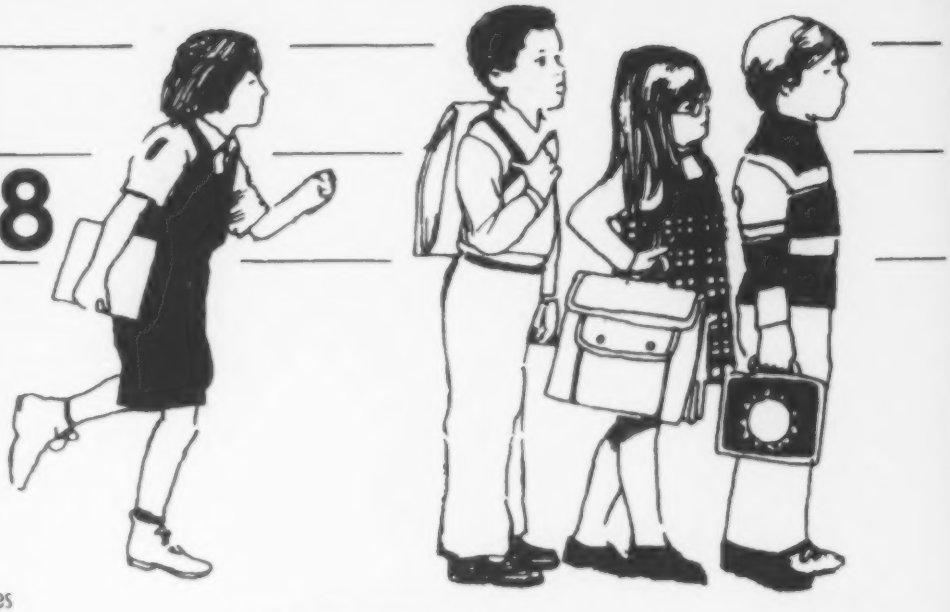

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Child Health USA 1998

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PREFACE **5**

INTRODUCTION **6**

I. POPULATION CHARACTERISTICS **10**
Population of Children 11
Children in Poverty 12
Maternal Age 13
Working Mothers 14
School Dropouts 16

II. HEALTH STATUS **17**
Infant
Low Birth Weight 18
Very Low Birth Weight 19
International Infant Mortality Rates 20
Infant Mortality 21
Neonatal and Postneonatal Mortality 22
Maternal Mortality 23
Infant Feeding 24
Child
Child Mortality 26
Childhood Deaths Due to Injury 27
Hospitalization 28
Hospital Discharge Trends 29
Vaccine-Preventable Disease 30
Pediatric AIDS 31
Child Abuse and Neglect 32
Adolescent
Adolescent Mortality 34
Adolescent Deaths Due to Injury 35
Sexual Activity and Condom Use 36
Abortion among Adolescents 37
Adolescent Childbearing 38
Adolescent STDs 39
Adolescent AIDS, by Race/Ethnicity 40
Adolescent AIDS, by Gender 41
Young Adult AIDS, by Race/Ethnicity 42
Substance Abuse 43
Cigarette Smoking 44
Overweight 45
Physical Activity 46

III. HEALTH SERVICES UTILIZATION **48**
Health Care Financing 49
Vaccination Coverage 50
Immunization Schedule 51
Dental Screening 52
Physician Visits 53
Place of Physician Contact 54
Service Utilization by Children with Chronic Conditions 55
Hospital Utilization 56
Prenatal Care 58

IV. STATE-SPECIFIC DATA **60**
Infant and Neonatal Mortality 61
Prenatal Care, Low Birth Weight, and Births to Women Under 18 62
Medicaid Recipients, Expenditures and EPSDT Services 63
Health Insurance Status 64
Uninsured Children (Map) 65

V. CITY DATA **66**
Infant Mortality 67
Low and Very Low Birth Weight 68
Prenatal Care 69

VI. PROGRESS TOWARDS HEALTHY PEOPLE 2000 OBJECTIVES **71**
References 77
Contributors 80

6

PREFACE

Child Health USA 1998 is the Health Resources and Services Administration's ninth annual report on the health status and service needs of America's children. This book is a compilation of secondary data for 55 health status indicators. It provides both graphical and textual summaries of data, and addresses long-term trends where applicable.

Child Health USA is published to provide the most current data available for public health professionals and other individuals in the private and public sectors. The succinct format of the book is intended to facilitate the use of the information as a snapshot of measures of the health of children in the United States.

Data are presented for the target populations of Title V funding: infants, children, adolescents, and women of childbearing age. In addition to health status, the book addresses health services utilization and population characteristics. This information provides the reader with a multi-dimensional perspective of the health of children in the United States, in accordance with the World Health Organization's definition of health: "A state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity."

The first section, *Population Characteristics,* presents statistics on factors that influence the well-being of children. The second section, entitled *Health Status,* contains vital statistics and health behavior information for infants, children, adolescents, and women of childbearing age. The third section, *Health Services Utilization,* contains data regarding health care financing and newly implemented health policies. The fourth and fifth sections contain information on selected indicators at state and city levels. This edition also includes a special section that cross-references 26 indicators with their respective Healthy People 2000 Objectives.

We hope the information provided in this book will be helpful to policy and decision-makers responsible for implementing or expanding programs that affect the health of children in the United States.

Health Resources and Services Administration
Maternal and Child Health Bureau

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INTRODUCTION

Our commitment to the health of children, youth and families is reflected not only in the health care services they receive, but in our efforts to keep them healthy. Prevention, through services such as prenatal care and immunization as well as promotion of healthy choices in life, is critical to assuring that children are born healthy and grow up healthy. These choices affect both children and their families, beginning early in pregnancy and continuing throughout childhood, adolescence, and young adulthood, and require the continuing effort of individuals, communities, and health care providers. The ultimate goal is not simply the prevention of unnecessary morbidity and mortality, but the promotion of health and well-being for the child and family.

The indicators in this book reflect a mixed picture of our efforts to prevent health problems among children. Although rates of maternal and infant mortality have dropped dramatically in this century, the United States still has one of the highest rates of infant death in the industrialized world. In 1996, of every 1,000 live births, 7.3 babies died in their first year of life, and in many communities the rate of infant mortality is much higher. While the 1996 infant mortality rate reflects a decline from the 1995 rate of 7.6, the rate of infant mortality among African Americans is 2.4 times that of whites.

One route toward prevention of infant mortality is improvement of infants' health at birth. The rate of low birth weight, a weight of 2500 grams (about 5.5 pounds) or less at birth, has remained stable at approximately 7.4 percent of all live births. Very low birth weight babies, weighing 1500 grams or less (about 3.3 pounds), represent 1.4 percent of births. Very low birth weight babies are particularly likely to have long-term health and developmental problems.

Good health care during (and before) pregnancy, in turn, can help to prevent these infant health problems. Overall, 82 percent of pregnant women begin prenatal care in the first 3 months of pregnancy, but this rate is lower for younger women and for African American women. Four percent of infants are born to women who receive no prenatal care at all or who do not receive care until their last trimester.

Breastfeeding is another important step families can take to assure the health of their babies. Breast milk has a number of preventive health benefits for both mother and child. The benefits of breastfeeding include prevention of diarrhea and infections in infants, as well as long-term preventive effects for the mother, including earlier return to pre-pregnancy weight and reduced risk of premenopausal breast cancer and osteoporosis. In 1997, 62 percent of mothers reported breastfeeding their babies right after delivery, the highest rate in recent years. However, rates of breastfeeding decline dramatically after the initial months of life, and only 26 percent report that they are still breastfeeding their infants at 6 months of age. These rates are even lower among African American women and young mothers; 41 percent of African American women report breastfeeding in the hospital, but only 14 percent breastfed at 6 months.

As children grow older, prevention efforts for most children shift to avoiding the hazards of childhood. Although death rates for children have declined substantially over the past several decades, injuries—most of which are preventable—are the leading cause of death for children under age 15, causing the deaths of 2,147 children in 1996. The leading causes of death due to injury are motor vehicle crashes (5.3 deaths per 100,000 children under age 5 and 5.4 deaths per 100,000 children ages 5–14), drowning (3 deaths per 100,000 children under age 5 and 1.1 deaths per 100,000 children ages 5–14) and fires and burns (2.6 deaths per 100,000 children under age 5 and 0.8 deaths per 100,000 children ages 5-14). These numbers, of course, do not include all of the children whose injuries are not fatal but result in short- or long-term disability.

Immunization is a critical preventive health service. The percentage of children who receive a full series of immunizations—including those for measles, mumps, rubella (German measles), polio, diphtheria, tetanus, pertussis (whooping cough), and *Haemophilus influenzae* type b, the bacterium that causes meningitis—reached the highest level ever recorded in 1996, with 77 percent of children aged 19-35 months fully immunized. However, significant progress is still needed to reach the goal of immunizing at least 90 percent of children by their second birthday.

Prevention efforts appear to be succeeding in reducing rates of pediatric Acquired Immune Deficiency Syndrome (AIDS). Only 473 new cases of AIDS in children were reported in 1997, a number that continues to decline each year, and the rate of pediatric AIDS has gone down nearly 50 percent since 1992. However, more than 80 percent of these new cases were in black and Hispanic children, emphasizing the need to target prevention efforts in minority communities and to increase access to treatment for HIV-positive pregnant women.

HIV/AIDS continues to be a threat to the lives and health of adolescents and young adults. In 1997, 397 new AIDS cases were reported among teens (under age 20) and 1,855 new cases were reported among young adults (under age 25). Almost half (49%) of the new adolescent AIDS cases were young women, for whom heterosexual contact was the major identified source of transmission, reinforcing the need for education regarding AIDS prevention for adolescents of both sexes.

Adolescence is a time of risk-taking, but it is also the time when lifelong health habits are formed. The indicators in this book show improvement in some areas of adolescent health, but teens are still exposed to a number of risks that threaten both their health and their potential for independence and success in life. For example, approximately five percent of 10th through 12th graders dropped out of school in 1996; school dropout is most common among African American women and Hispanics of both sexes.

Unplanned childbearing early in life also presents a major obstacle to education and economic independence. Rates of childbearing among adolescents have declined in all states since 1991, and the greatest declines were seen among African American teens. Nonetheless, in 1996, there were 519,577 births to young women between the ages of 15 and 19, including 11,242 births to young women under age 15. Since young mothers are less likely to receive timely prenatal care, and more likely to expose their infants to risks such as prenatal smoking and inadequate weight gain, prevention of unintended pregnancy among adolescents can contribute greatly to improved infant health.

Smoking and substance abuse also remain major threats to the health of adolescents. In 1997, 19 percent of eighth graders reported smoking in the past 30 days, as did 30 percent of tenth graders and 36 percent of high school seniors. Among seniors, this rate reflects a continuing annual increase in smoking rates. Because tobacco use often remains a lifelong habit with serious health consequences, the prevention of smoking among children and adolescents is a major priority for the Administration.

One important way to assure that children receive both the preventive and treatment services they need is to provide health insurance to cover these services. The State Child Health Insurance Program, created under the Balanced Budget Act of 1997, allows States to extend comprehensive insurance to children in low-income families who are not eligible for the Medicaid program. This program has the potential to provide coverage to approximately 5.8 million children, increasing their chances of receiving timely health, including dental health, services as well as providing their families with information about staying healthy.

The statistics presented here paint a picture of continuing progress toward the goal of healthy children and families, but we still have a long way to go in many areas. On the National, state, and community levels, we can monitor our progress using the Healthy People 2000 Objectives for the Nation. These 319 objectives, developed in 1990 by a consortium of government, voluntary, and professional organizations, are targeted toward 22 priority areas, such as family planning, nutrition, and maternal and infant health. In addition to these national goals, 42 states and territories have established their own statewide objectives. Although the methods used to calculate the specific statistics in this book may not precisely coincide with the way these national and state-level objectives are measured, the information presented here will provide readers with timely and accurate data that allows for an overview of progress toward the nation's maternal and child health objectives for the year 2000.

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POPULATION CHARACTERISTICS

Socio-demographic characteristics provide a comprehensive picture of the country's diverse maternal and child population. Through the year 2000, the proportion of children ages 21 and below is projected to remain between 31.5% and 31.6%.

At the national, state, and local levels, policy-makers use population information to systematically address health-related issues of mothers and children. By carefully analyzing and comparing data, health workers can often isolate high-risk populations that require specific interventions. Policy-makers can then tailor programs to meet the needs of those populations.

The following section presents data on several population characteristics that have an impact on maternal and child health program development and evaluation. These include age, poverty status, living arrangements by head of household, school dropout rates, and child care trends.

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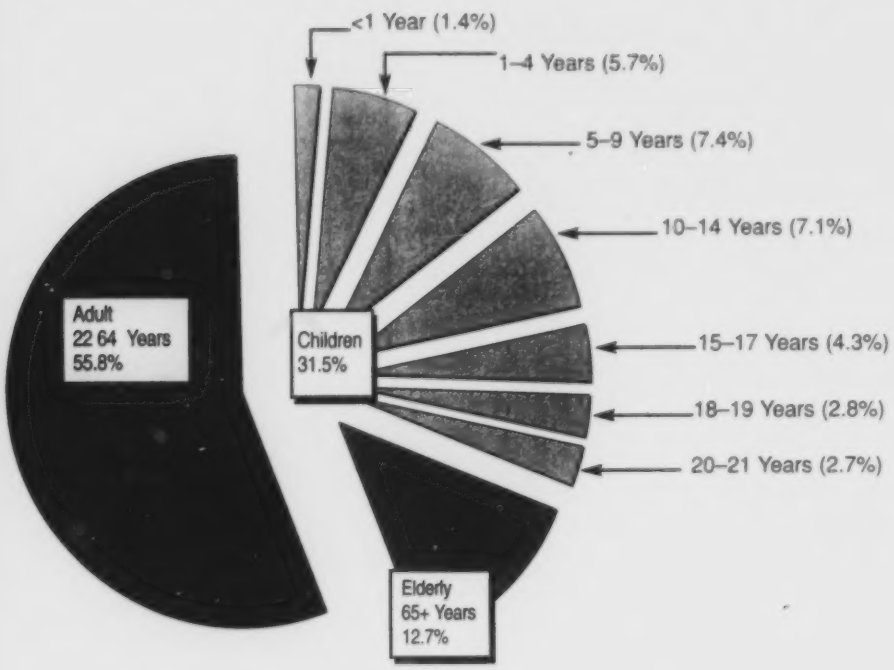
U.S. RESIDENT POPULATION BY AGE GROUP: JULY 1, 1997

Source (I.1): U.S. Bureau of the Census



POPULATION OF CHILDREN

In 1997, the 84 million children through the age of 21 in the United States represented 31.5% of the total population. Persons aged 65 and over represented 12.7% of the total population. The median age in the United States for all races was 34.9.

Since 1990, the number of children under 5 years of age has increased by 1.6%. The number of children ages 5–19 years has increased 9%. Through the year 2000, the proportion of children through the age of 21 is projected to remain between 31.5% and 31.6%.

CHILDREN IN POVERTY

In 1996, there were 13.8 million related* children under 18 years of age living in families with income below the Federal poverty level of $15,600** for a family of four. This population comprised 19.8% of all related children living in families, or nearly one in every five children. Among black and Hispanic children, two in five children are poor.

Although the number of children in poverty has fallen by approximately 200,000 since 1995, this number still represents 2.7 million more children than were reported to be living in poverty in 1980. Over this same period, the number of persons 65 years of age and over living in poverty decreased by more than 400,000.

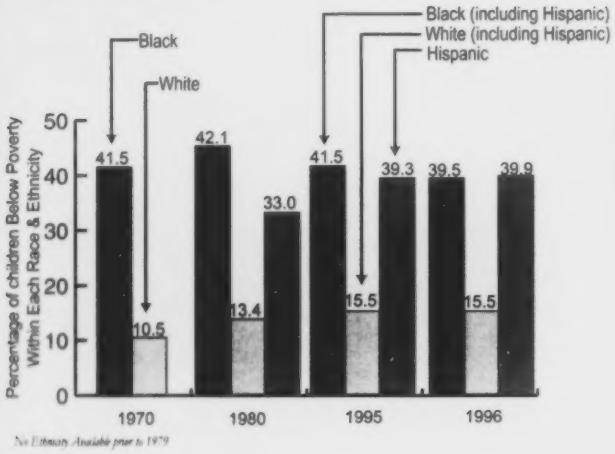
Of the 13.8 million related children under 18 years of age living in poverty, 58% live in homes headed by a single mother, while 37% live in homes headed by married parents and 5% live with a single father.

Related children in a family includes householder's own children and all other children in the household who are related to the householder by blood, marriage, or adoption.

**Based on the U.S. Census Bureau's poverty threshold, which is calculated using the Consumer Price Index from the previous calendar year.*

RELATED CHILDREN UNDER 18 YEARS OF AGE LIVING IN FAMILIES BELOW 100% OF POVERTY LEVEL: 1996

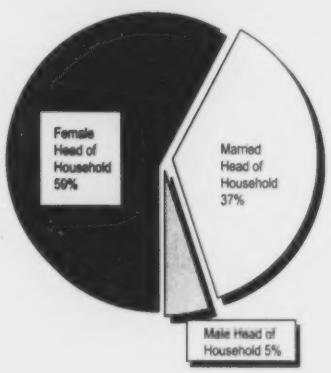
Source:(I.2): U.S. Bureau of the Census



No Ethnicity Available prior to 1979

RELATED CHILDREN UNDER 18 YEARS OF AGE LIVING IN FAMILIES BELOW 100% OF POVERTY LEVEL, BY HOUSEHOLD STATUS: 1996

Source:(I.2): U.S. Bureau of the Census



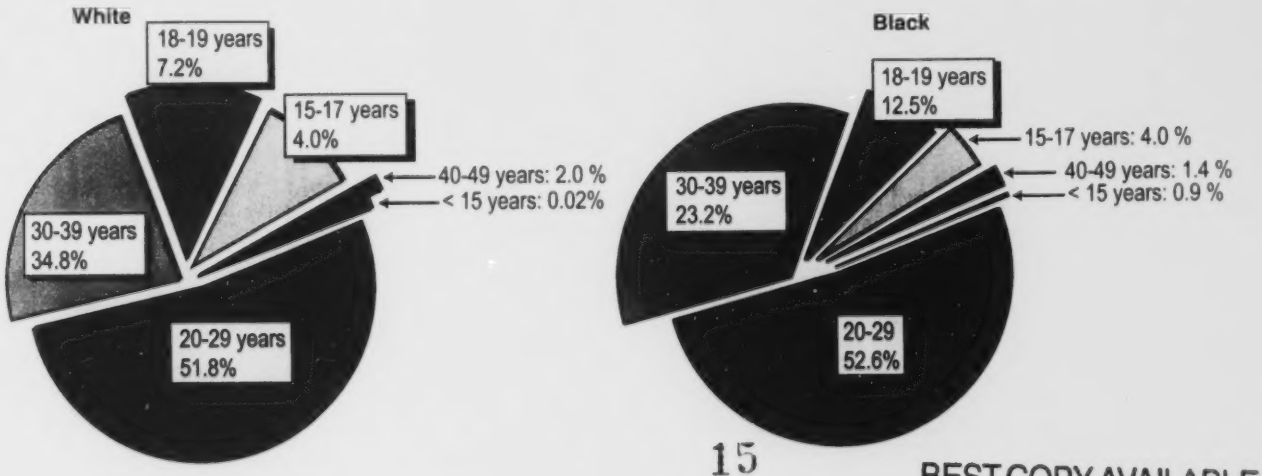
MATERNAL AGE

In 1996, while birth rates among teenagers declined, birth rates for women in their thirties continued to increase, and rates for women in their twenties showed an increase for the first time since 1990. Of all births in 1996, just over half were to women in their twenties, one third were to women in their thirties, and 12.9 percent were to teens. The remaining 1.9 percent of births were to women in their forties.

Among both black and white women, more than half of births in 1996 were to women in their twenties. The percentage of births that are to women in their teens, however, is twice as high among blacks as among whites.

PERCENT DISTRIBUTION OF BIRTHS BY MATERNAL AGE, BY RACE, 1996

Source (I.3): National Center for Health Statistics



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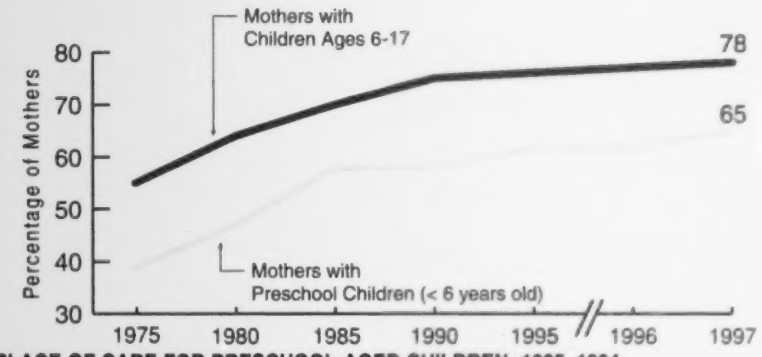
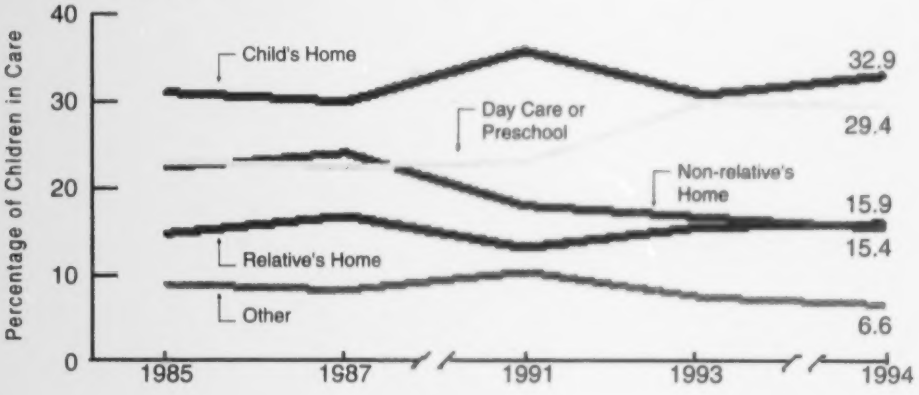
MOTHERS IN THE LABOR FORCE: 1975–1997

Source (I.4): U.S. Bureau of Labor Statistics



PLACE OF CARE FOR PRESCHOOL-AGED CHILDREN: 1985–1994

Source (I.5): U.S. Bureau of the Census



WORKING MOTHERS

In 1997, 65 percent of mothers with preschool aged children (younger than 6 years) were in the labor force (either employed or looking for work), and 60 percent were actually employed. Of those mothers, 70 percent were employed full-time and 30 percent worked part-time.

Of women with children ages 6–17, 78 percent were in the labor force in 1997 and 74 percent were actually employed. Of employed mothers, 76 percent worked full-time and 24 percent worked part-time.

**Data for 1994 and 1995 are not strictly comparable with data for earlier years due to changes in the survey and the estimation process.*

CHILD CARE

In 1994, 3 out of 10 children younger than age 5 (3 million) whose mothers were employed* spent their days in nonresidential day care centers. Women who work full time tend to use day care centers while women who work part time are more likely to use in-home care.

**Some of those mothers may have worked at home.*

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SCHOOL DROPOUTS

As of October 1996, approximately 485,000 youths ages 15–24 had dropped out of high school in the previous 12 months. Those who dropped out of high school during this period represented 5% of students enrolled in high school in 1995.

In 1996, Hispanic students were the most likely to drop out, and dropouts represented nearly one-third of Hispanic young adults. However, the gap in the dropout rates between black and white young adults has narrowed considerably in the last 25 years, as the dropout rate decreased faster for blacks than for whites.

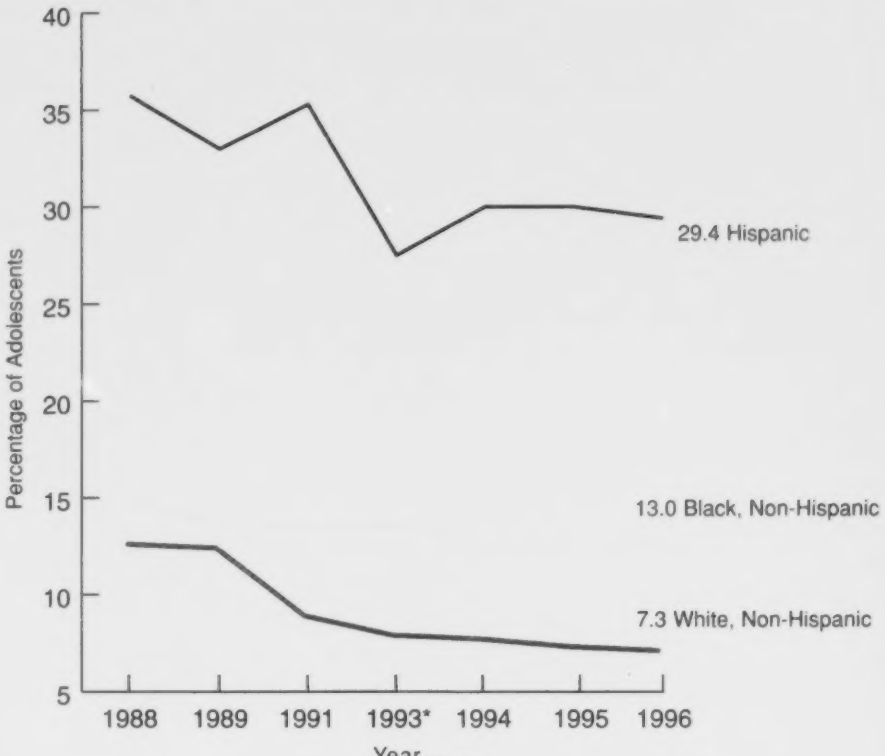
Those students most likely to drop out of school in 1996 were Hispanic youth; students who remain in school after the majority of their age cohort has left; and students over the age of 19. Also, students living in low-income families were five times more likely to drop out of high school than those in higher-income families.

Note: Status rates measure the proportion of the population who have not completed high school and are not enrolled at one point in time, regardless of when they dropped out.

**Because of changes in data collection procedures beginning in 1992, data may not be comparable with figures for earlier years.*

STATUS SCHOOL DROPOUT RATES FOR AGES 16–24 BY RACE/ETHNICITY: 1988–1996

Source (1.6): U.S. Department of Education



HEALTH STATUS

The systematic assessment of the health status of children enables health professionals to determine the impact of past and current health intervention and prevention programs. Program planners and policy-makers identify trends by examining and comparing information from one data collection year to the next. Although indicators are often assessed on an annual basis, some surveillance systems may only collect data every two, three, or five years.

In the following section, mortality, disease, injury, and health behavior indicators are presented by age group. The health status indicators in this section are based on vital statistics and national surveys. Population-based samples are designed to yield data that are representative of the maternal and child population that are affected by, or in need of, specific health services.

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LOW BIRTH WEIGHT

In 1996, 287,230 babies (7.4% of all live births) were of low birth weight, weighing less than 2,500 grams, or about 5.5 pounds, at birth.

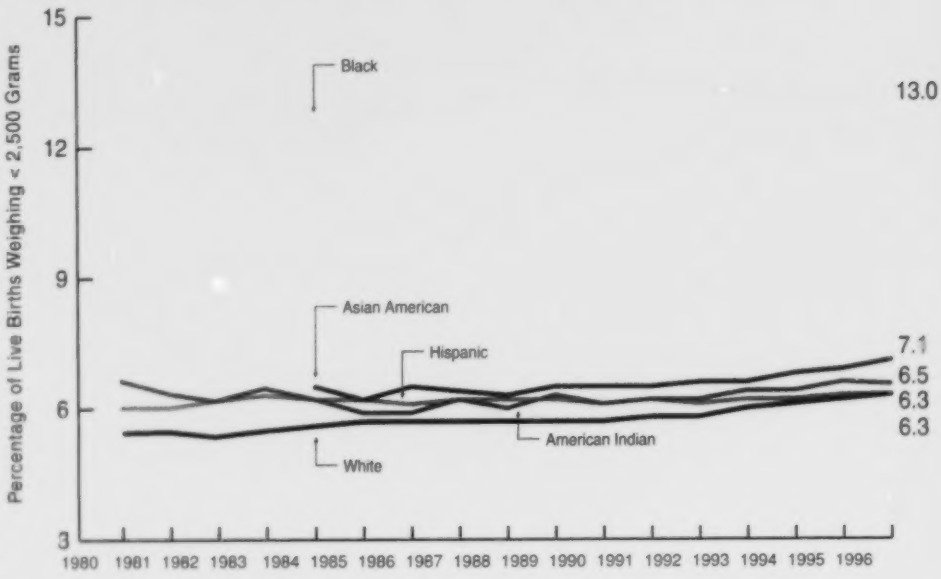
The percentage of low birth weight births rose from a low of 6.8% in 1985 to 7.4% in 1996. Low birth weight increased among white mothers from 6.2% to 6.3%. Although the rate of low birth weight is still more than twice as high among infants born to black women (13.0%), the rate of low birth weight for black infants has been dropping since 1992.

Low birth weight is the factor most closely associated with neonatal mortality. Low birth weight infants are more likely to experience long-term disabilities or to die during the first year of life than are infants of normal weight.

In 1996, 12.1% of infants born to smokers were of low birth weight, compared with 6.9% of births to nonsmokers. The nearly twofold differential has been observed since 1989 among both black and white infants. Other factors associated with increased risk of low birth weight include poverty, low level of educational attainment and minority status.

PERCENTAGE OF INFANTS BORN AT LOW BIRTH WEIGHT BY RACE: 1980–1996

Source (II.1): National Center for Health Statistics



*Hispanic can be of any race.

VERY LOW BIRTH WEIGHT

In 1996, rates of very low birth weight remained virtually unchanged at 1.4 percent of live births for U.S. women overall.

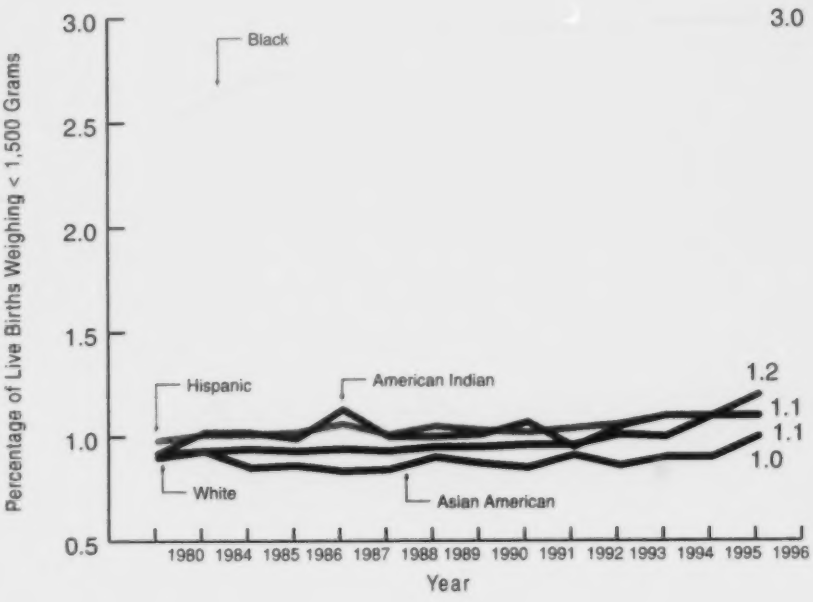
Although infants weighing less than 1500 grams (about 3.3 pounds) account for a small percentage of births, they account for up to half of the deaths of newborns. More than 9 of 10 of the very smallest infants—those with birth weights of less than 500 grams—die within the first year of life.

Very low birth weight infants who survive are at significantly increased risk of severe problems, including physical and visual difficulties, developmental delays and cognitive impairment requiring increased levels of medical, educational and parental care.

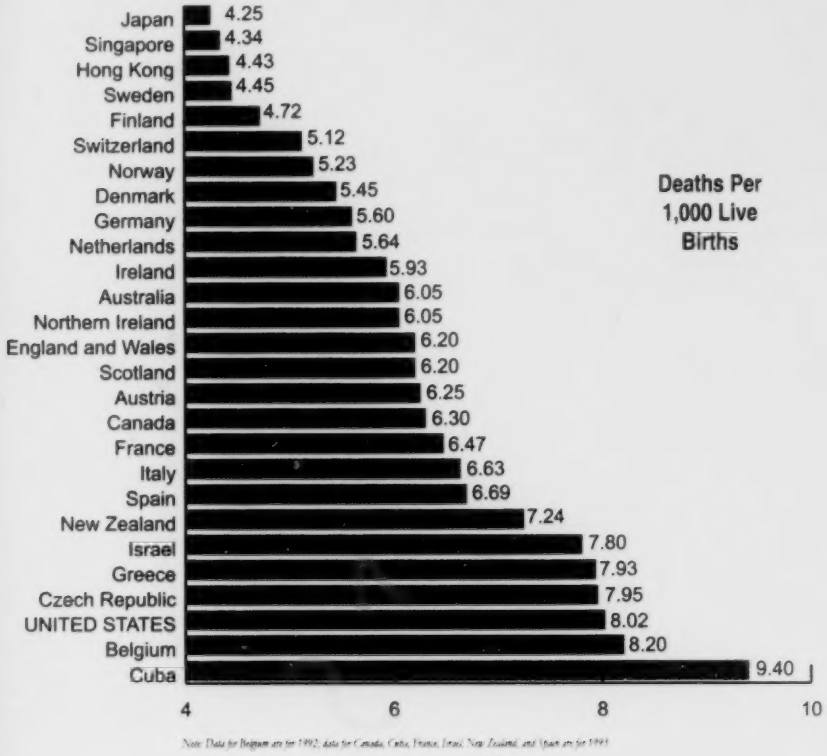
The rate of very low birth weight among black babies is almost three times as high as that among whites, and are twice the rate for the total birth population. This disparity is a major contributor to the disparity in infant mortality rates between black and white infants.

PERCENTAGE OF INFANTS BORN AT VERY LOW BIRTH WEIGHT BY RACE: 1980–1996

Source (II.1): National Center for Health Statistics



COMPARISON OF NATIONAL INFANT MORTALITY RATES: 1994
Source: (II.2): National Center for Health Statistics



Note: Data for Belgium are for 1992; data for Canada, Cuba, France, Israel, New Zealand, and Spain are for 1993.

COMPARISON OF NATIONAL INFANT MORTALITY RATES

Differences in the infant mortality rates among industrialized nations reflect differences in the health status of women before and during pregnancy and the quality of primary health care accessible to pregnant women and their infants. Although the United States has greatly reduced its infant mortality rate since 1965, the nation ranked 25th among industrialized countries in 1994.

Since 1980, Japan has had the lowest infant mortality rate in the world. In 1994, the risk of a Japanese child dying in infancy (4.3 per 1,000) was 46% lower than that observed in the United States (8.0 per 1,000 live births).

INFANT MORTALITY

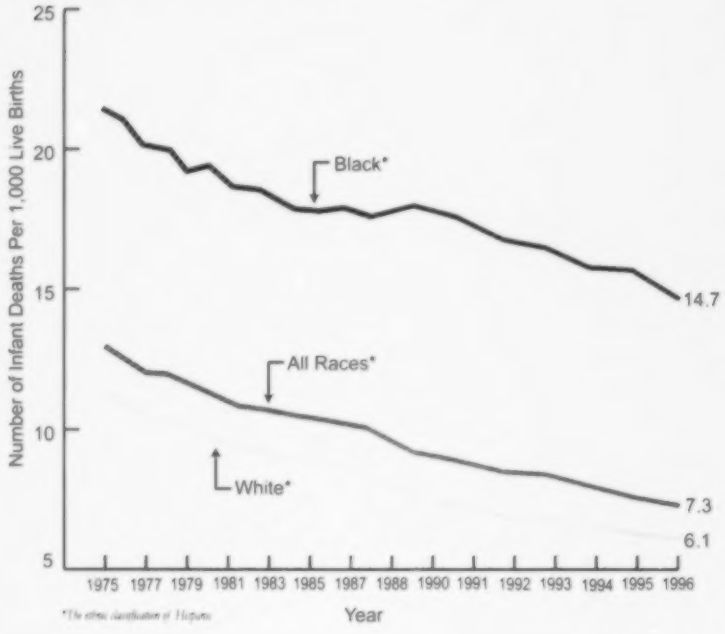
In 1996, 28,487 infants died before their first birthday. The infant mortality rate was 7.3 deaths per 1,000 live births. This figure represents a decline of almost 4% from the rate of 7.6 for the previous year.

The rapid decline in infant mortality, which began in the mid-1960s, slowed for both blacks and whites during the 1980s.

The 1996 infant mortality rate for black infants was 2.4 times the rate for white infants. Although the trend in infant mortality rates among blacks and whites has been on a continual decline throughout the 20th century, the proportional discrepancy between the black and white races has remained largely unchanged.

U.S. INFANT MORTALITY RATES BY RACE OF MOTHER: 1975–1996

Source (II.3): National Center for Health Statistics



*The ethnic classification of Hispanic

NEONATAL AND POSTNEONATAL MORTALITY

Neonatal

In 1996, 18,572 infants younger than 28 days died, resulting in a neonatal mortality rate of 477.2 deaths per 100,000 live births. Both the overall mortality rate and rates by most leading causes of mortality decreased from 1995 to 1996.

Disorders resulting from short gestation and low birth weight are the primary causes of neonatal mortality for blacks, while congenital anomalies are the leading causes for whites.

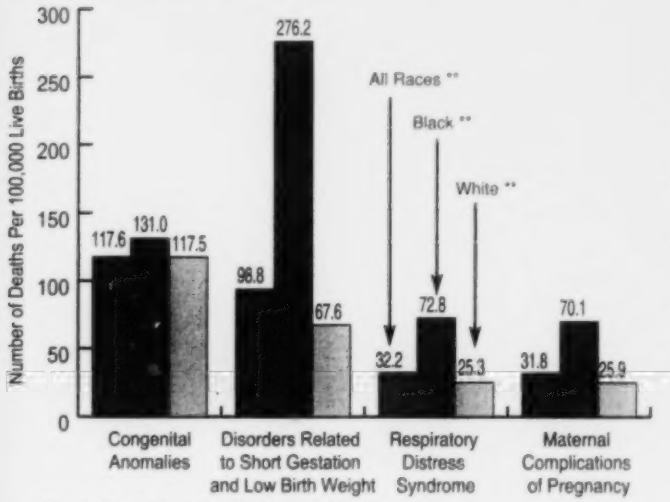
Postneonatal

In 1996, 9,915 infants 28 days to 11 months old died; the postneonatal mortality rate was 254.8 deaths per 100,000 live births, a decrease of almost 5% from 1995.

The postneonatal mortality rate for blacks is at least two times that for whites for most of the leading causes of postneonatal mortality.

LEADING CAUSES OF NEONATAL* MORTALITY: 1996

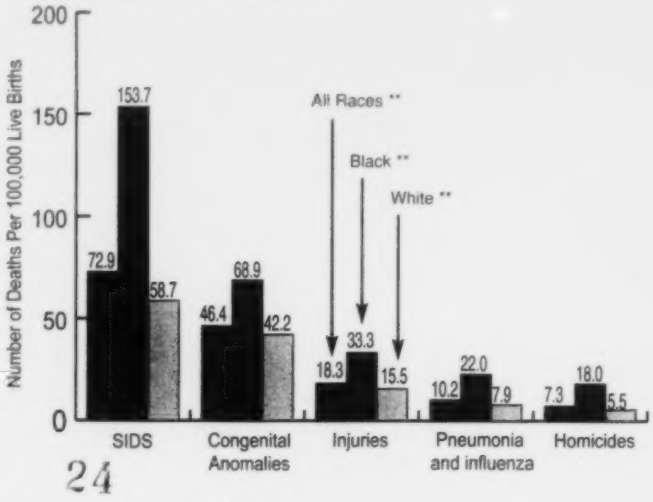
Source (IL3): National Center for Health Statistics



*Neonatal: less than 28 days old. **Includes Hispanic

LEADING CAUSES OF POSTNEONATAL* MORTALITY: 1996

Source (IL3): National Center for Health Statistics



*Postneonatal: 28 days to less than 1 year old. **Includes Hispanic

MATERNAL MORTALITY

During the past several decades, there has been a dramatic decrease in maternal mortality in the United States. Since 1980, however, the rate of decline has slowed, and the maternal mortality rate actually increased from 1995 to 1996.

In 1996, there were 294 maternal deaths which resulted from complications during pregnancy, childbirth, or the postpartum period.

The maternal mortality rate for black women (20.3 per 100,000 live births) is almost four times the rate for white women (5.1 per 100,00 live births).

Regardless of race, the risk of maternal death increases for women over age 30; women 35–39 years old have more than twice the risk of maternal death than those aged 20–24 years.

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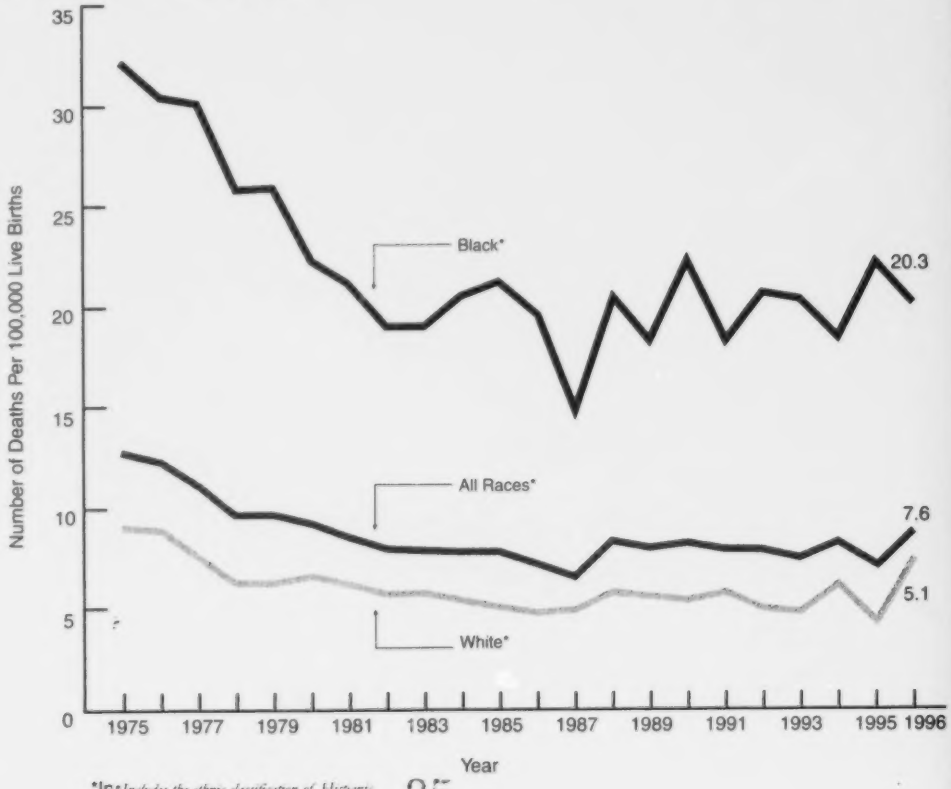
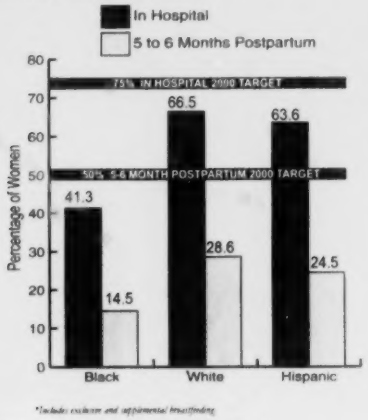
MATERNAL MORTALITY RATES BY RACE OF MOTHER: 1975–1996

Source (II.3): National Center for Health Statistics



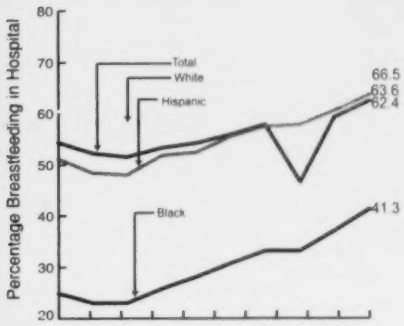
In Includes the ethnic classification of Hispanic

BREASTFEEDING BY RACE: 1997
Source (II.4): Abbott Laboratories



*Include exclusive and supplemental breastfeeding

BREASTFEEDING BY RACE: 1997
Source (II.4): Abbott Laboratories



INFANT FEEDING

Throughout the 1970s and early 1980s, the percentage of mothers who began breastfeeding in the hospital increased steadily to 61.9%, but then gradually declined to 51.5% by 1990. Since 1991, an increase in rates for black, Hispanic, and white women has produced a rate of 62.4% in 1997, the highest in recent years.

Since 1990, rates of breastfeeding immediately after delivery grew the most among groups of mothers that have traditionally been the least likely to breastfeed, such as black and Hispanic women. Over the past eight years, the rate of breastfeeding has increased 80% among black women and 33% among Hispanic mothers. These increases have contributed to a substantial reduction in the gap in breastfeeding rates between white and non-white women.

Breastfeeding rates for women of all races decrease substantially between delivery and 6 months postpartum, the breastfeeding period recommended as most critical for the infant's health by the Surgeon General of the United States. The percentage of women who report that they are still breastfeeding at 6 months postpartum in 1997 increased since 1996, but were only 28.6%, 24.5%, and 14.5% for white, Hispanic, and black women respectively. These rates represent a sharp decline from rates immediately after delivery of 37.9% among whites, 39.1% among Hispanics, and 26.8% among blacks.

Breastfeeding rates were highest among women over 35 years of age, college-educated, not participating in the Women, Infants, and Children (WIC) dietary supplement program, and/or living in the western states. Women were also more likely to breastfeed their first child. Women least likely to breastfeed were younger than 20 years of age, not employed, low-income, black and/or living in the southeastern United States.

27

CHILD MORTALITY

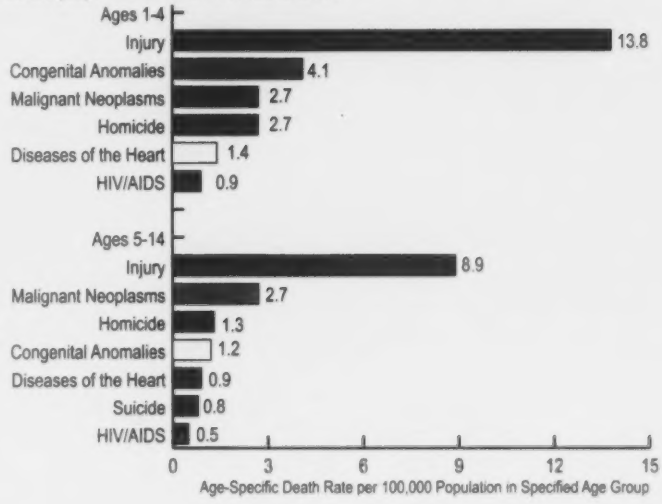
There were 14,278 deaths of children ages 1–14 in 1996. Injury, of any type, and regardless of intent, was the primary cause of death in that age group. Among 1- to 4-year-old children, injuries accounted for 36% of all deaths, followed by deaths due to congenital anomalies (birth defects), malignant neoplasms (cancer), homicide, diseases of the heart, and HIV or AIDS.

Injuries comprised 41% of all deaths among 5- to 14-year-old children, followed by malignant neoplasms, homicide, congenital anomalies, diseases of the heart, suicide, and HIV or AIDS.

Childhood death rates have declined substantially over the past several decades. Death rates for those aged 1–4 years decreased almost 6% from 1995, while rates for those aged 5–14 years decreased more than 3%.

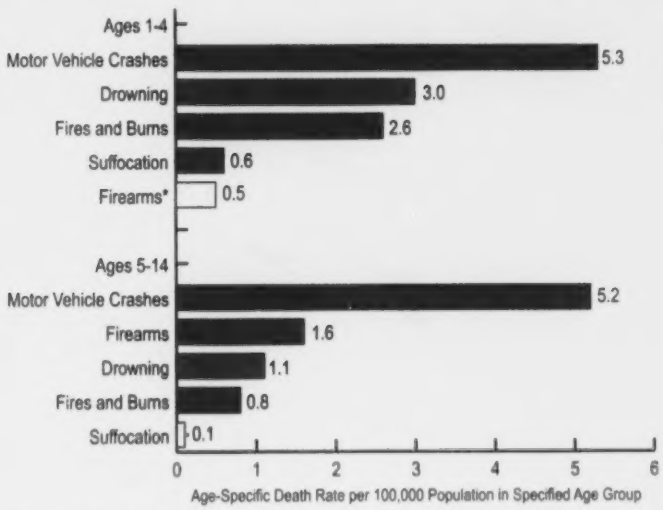
LEADING CAUSES OF DEATH IN CHILDREN AGES 1-14: 1996

Source (IL3): National Center for Health Statistics



CHILDHOOD DEATHS DUE TO EXTERNAL CAUSE, BY CAUSE AND AGE: 1996

Source (II.3): National Center for Health Statistics

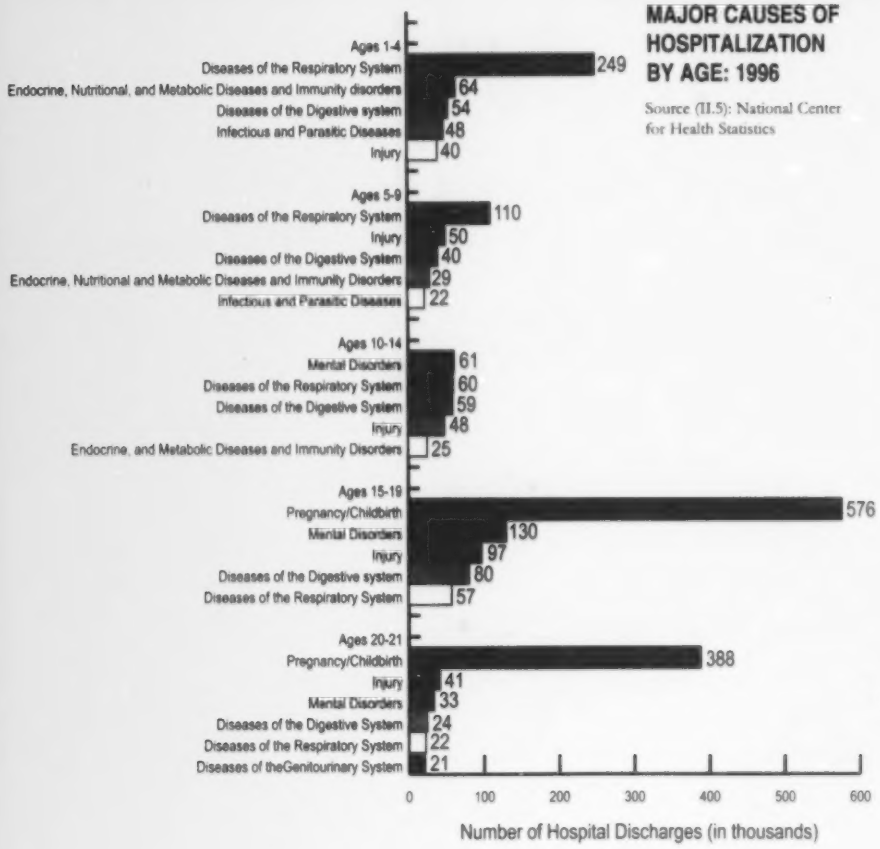


*Firearms related deaths include homicides, suicides, and accidents.

CHILDHOOD DEATHS DUE TO INJURY

In 1996, injuries caused the deaths of 2,147 1- to 4-year-old children and 3,433 5- to 14-year-old children.

Among 1- to 4-year-old children, motor vehicle crashes, drowning, and fire were the leading causes of injury death. Motor vehicle crashes were the leading cause of injury death among 5- to 14-year-old children, followed by firearm deaths. About 51% of firearm deaths among 5- to 14-year-old children were homicides.



MAJOR CAUSES OF HOSPITALIZATION BY AGE: 1996

Source (II.5): National Center for Health Statistics

HOSPITALIZATION

In 1996, there were 3.3 million hospital discharges of children 1 through 21 years old, or 4.1 discharges per 100 children that year.

Diseases of the respiratory system were the major causes of hospitalization for children 1–9 years of age and accounted for 34% of their discharges.

Hospital discharge rates generally decrease until about age 9 and then increase during later adolescence.

While injuries are the leading cause of death for children older than 1 year, this category accounted for only 9% of the hospital discharges of children 1 to 14 years old in 1996. Pregnancy and childbirth accounted for 69% of discharges of young women ages 15–21.

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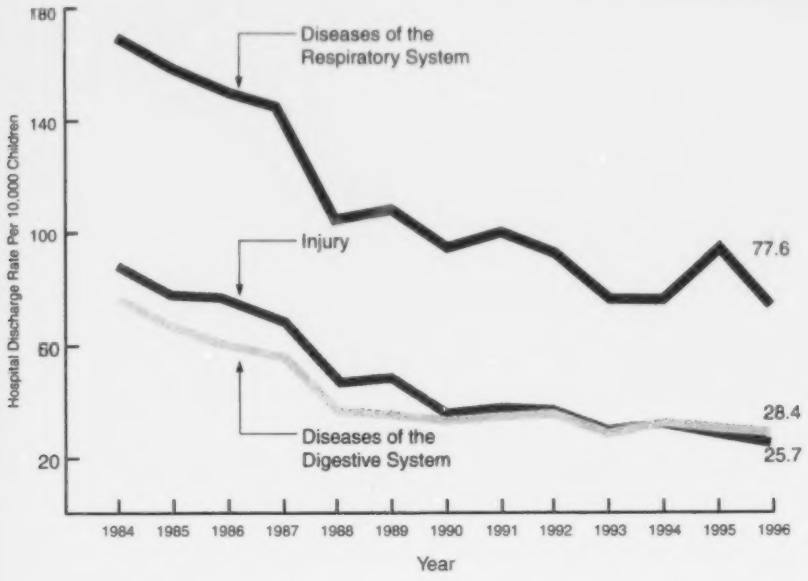
DISCHARGE RATE OF PATIENTS 1–14 YEARS OLD FOR SELECTED DIAGNOSES 1984–1996

Source (II.5): National Center for Health Statistics



HOSPITAL DISCHARGE TRENDS

Since 1984, there has been a 45% decrease in overall hospital discharge rates for children aged 1–14 years.

Between 1984 and 1996, there was a 45% decline in the hospital discharge rate for diseases of the respiratory system in children in this age group.

Three diagnostic categories (respiratory diseases, injury, and digestive diseases) accounted for 48% of the discharges of children aged 1–14 years in 1996.

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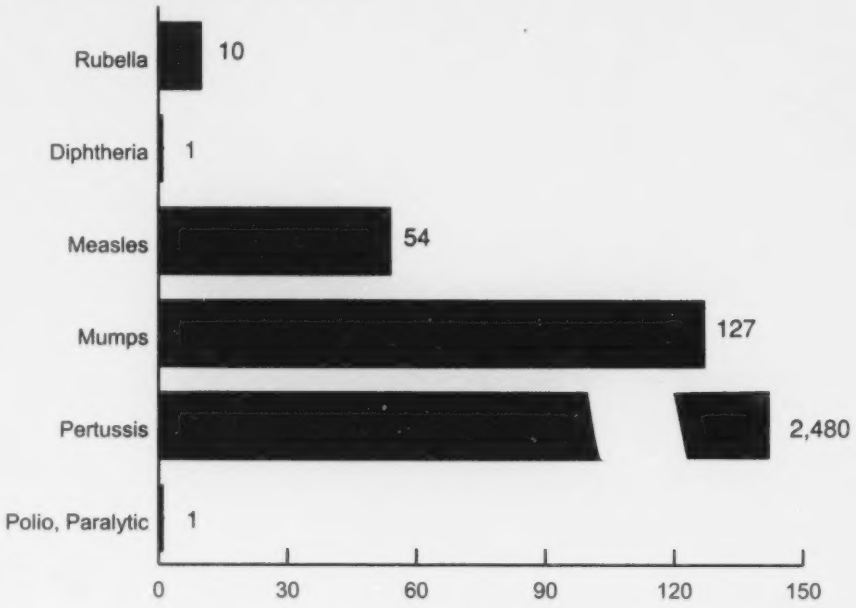
VACCINE-PREVENTABLE DISEASES

The number of reported cases of vaccine-preventable diseases has decreased steadily since the introduction of the Childhood Immunization Initiative. The number of reported cases of rubella, poliomyelitis, pertussis, mumps, measles, hepatitis B, and *H. influenzae* decreased significantly between January 1996 and December 1997. Our progress in the control of vaccine-preventable diseases is exemplified in the decline in the number of cases of measles in children since the measles epidemic of the late 1980s. Also significant is the near-eradication of polio, with only 1 reported case among children under 5 years of age reported in 1997.

Although much progress has been made in reducing the number of reported cases of vaccine-preventable diseases, several of these diseases are still common. The number of cases of pertussis and mumps remains substantial and indicates a need to continue to promote immunization efforts.

VACCINE-PREVENTABLE DISEASES; NUMBER OF CASES OF REPORTABLE DISEASES AMONG CHILDREN UNDER 5: 1997

Source (II.6): Centers for Disease Control and Prevention



PEDIATRIC AIDS

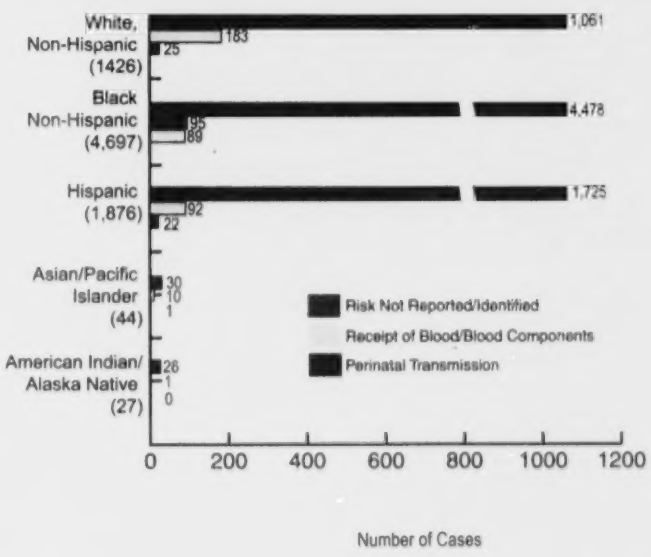
As of December 31, 1997, 8,086 cases of AIDS in children younger than 13 had been reported in the U.S.; this total includes 473 newly reported cases in 1997. Pediatric AIDS cases represented less than 1.3 percent of all cases reported to date.

The majority of pediatric AIDS cases result from transmission before or during birth (perinatal transmission). However, the number of cases of pediatric AIDS due to perinatal transmission has declined by nearly 50 percent since 1992. A major factor in this decline is the increasing use of zidovudine (ZDV) treatment during pregnancy to reduce perinatal HIV transmission. In 1994, the U.S. Public Health Service recommended this treatment for all HIV-positive pregnant women, and in 1995, routine HIV counseling and voluntary testing for all pregnant women were recommended.

The number of cases of pediatric AIDS in black, non-Hispanic children is more than three times that of white, non-Hispanic children and two and one-half times that of Hispanic children.

PEDIATRIC AIDS BY RACE/ETHNICITY AND EXPOSURE CATEGORY: 1981–1997

Source (II.7): Centers for Disease Control and Prevention



CHILD ABUSE AND NEGLECT

In 1996, investigations by child protective services agencies in 48 states determined that 968,748 children were victims of substantiated or indicated child abuse or neglect, equivalent to a rate of 15 per 1,000 children younger than 18 years of age. Seventy-seven percent of the perpetrators of child maltreatment were the parents of the victims. Another 11 percent were other relatives, and 2 percent were persons in other caretaking roles (e.g., foster parents, facility staff, and child care providers).

Approximately 25 percent of all victims were younger than 4 years old; more than half were 7 years of age or younger; about 26 percent were ages 8–12; and 20 percent were ages 13–17. Approximately 58 percent suffered neglect, 22 percent physical abuse, 12 percent sexual abuse, 6 percent emotional maltreatment, and 15 percent other forms of maltreatment. Some children suffered multiple types of maltreatment.

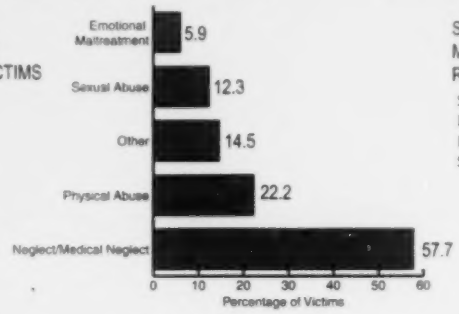
Forty-one states reported that a total of 917 children died from abuse or neglect. Available data suggest that the majority (76 percent) of children dying from abuse and neglect were under age 4.

The National Child Abuse and Neglect Data System (NCANDS) is the primary source of national information on abused and neglected children known to state child protective services agencies. In 1996, state child protective services agencies received and referred for investigation over 2 million reports alleging the maltreatment of just over 3 million children. Reports were received in almost equal proportions from community professionals and members of the general public (such as friends, relatives, or neighbors of the reported children).

Source: U.S. Department of Health and Human Services, National Center on Child Abuse and Neglect, Child Maltreatment 1996: Reports from the States to the National Child Abuse and Neglect Data System (Washington, DC: U.S. Government Printing Office, 1997).

PERCENTAGE OF CHILD ABUSE AND NEGLECT VICTIMS BY TYPE OF MALTREATMENT: 1996

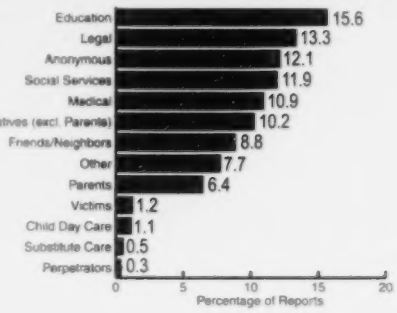
Source (II.8): U.S. Department of Health and Human Services



Note: Percentage may total more than 100% because some states report more than one type of maltreatment per victim. N=572,843 victims in 31 States.

SOURCES OF MALTREATMENT REPORTS: 1996

Source (II.8): U.S. Department of Health and Human Services

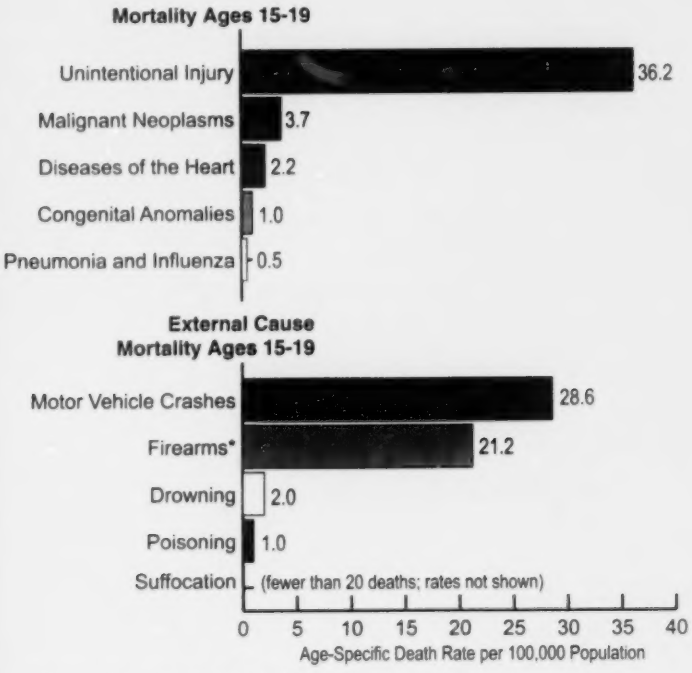


Note: 1,490,340 reports from 42 States.

35

LEADING CAUSES OF DEATH IN ADOLESCENTS AGES 15–19: 1996

Source (II.3): National Center for Health Statistics



*Firearm-related deaths include homicides, suicides, and accidents.

ADOLESCENT MORTALITY

In 1996, there were 14,663 deaths of adolescents aged 15–19 years. In that age group, injury was the leading cause of death. The 6,756 injury deaths accounted for 46% of all deaths among 15- to 19-year-olds in 1996. Malignant neoplasms (cancer) were the next leading cause of death, accounting for 4.7% of all deaths among 15- to 19-year-olds. Mortality among teenagers declined substantially between 1960 and the early 1980s. There was a moderate increase in mortality among 15- to 19-year-olds in the mid- to late 1980s. The death rate among that age group has been stable since then.

Motor vehicle crashes were the leading causes of injury mortality among 15- to 19-year-olds in 1996, accounting for approximately 79% of all injury deaths among teenagers. The next two leading causes of injury death—drowning and poisoning—each accounted for 3% to 5% of all injury deaths among 15- to 19-year-olds.

ADOLESCENT DEATHS DUE TO INJURY

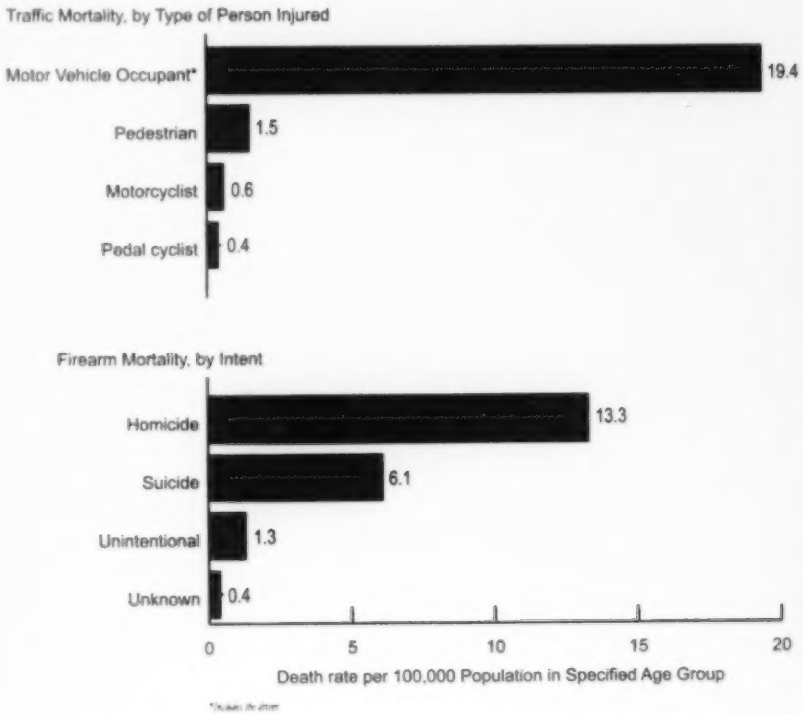
In 1996, motor vehicle crashes caused the death of 5,329 15- to 19-year-olds. About 68% of those killed were in motor vehicles, either as passengers or the driver. Deaths of pedestrians, motorcyclists, and others accounted for the remainder of motor vehicle mortality among teenagers.

Results of CDC's 1995 Youth Risk Behavior Surveillance System (YRBSS) survey revealed that in the 30 days preceding the survey, 21.7% of respondents had rarely or never used a safety belt, and 38.8% had ridden with a driver who had been drinking alcohol.

In 1996, 4,432 15- to 19-year-olds were killed by firearms in the U.S. Homicide accounted for 63% of firearm deaths among teenagers, 29% were suicide and 6% were considered to be unintentional. Results of CDC's 1995 YRBSS survey revealed that in the 30 days preceding the survey, 20% of respondents had carried a weapon. In the 12 months prior to the survey, 8.7% of respondents had attempted suicide.

MOTOR VEHICLE CRASHES AND FIREARMS MORTALITY AMONG ADOLESCENTS, AGES 15–19: 1996

Source (II.3): National Center for Health Statistics



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SEXUAL INTERCOURSE

Among high school students in the U.S., the percentage of students in 9th through 12th grades reporting ever having sexual intercourse increased significantly in 1995. Overall, black students were significantly more likely than white and Hispanic students to have had sexual intercourse.

Nearly 50% of students in the 12th grade reported having had sexual intercourse during the preceding three months. The prevalence rate of sexual activity increased significantly from grades 9 through 12 among both females (22.3% to 51.9%) and males (24.2% to 47.9%). Overall, male students were significantly more likely than female students (20.9% versus 14.4%) to have had four or more sex partners during their lifetime.

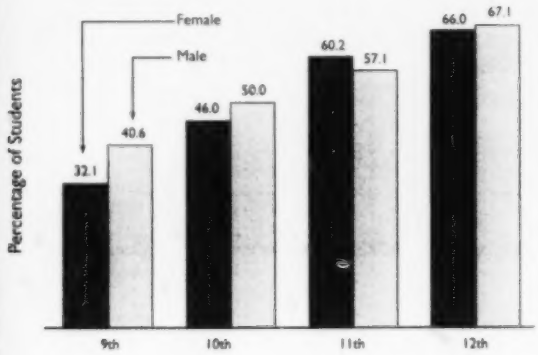
CONDOM USE

In 1995, more than half (54.5%) of sexually active 9th through 12th graders reported condom use during last sexual intercourse. Males were significantly more likely than females to have reported that a condom was used.

While sexual activity increased by grade for all students, condom use decreased by grade. Only 49% of sexually active 12th graders reported condom use, compared with 62.9% of sexually active 9th graders.

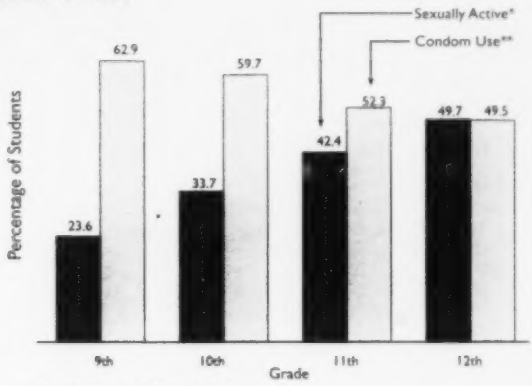
PERCENTAGE OF HIGH SCHOOL STUDENTS WHO HAVE EVER HAD SEXUAL INTERCOURSE, BY GRADE AND GENDER: 1995

Source (II.9): Centers for Disease Control and Prevention



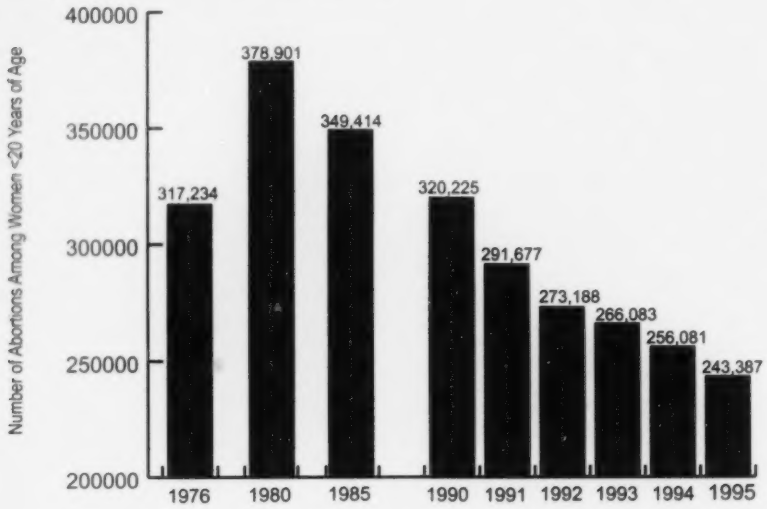
SEXUAL ACTIVITY AND CONDOM USE IN HIGH SCHOOL STUDENTS: 1996

Source (II.9): Centers for Disease Control and Prevention



ABORTIONS AMONG WOMEN UNDER 20 YEARS OF AGE: 1976–1995

Source (IL10): Centers for Disease Control and Prevention



ABORTION AMONG ADOLESCENTS

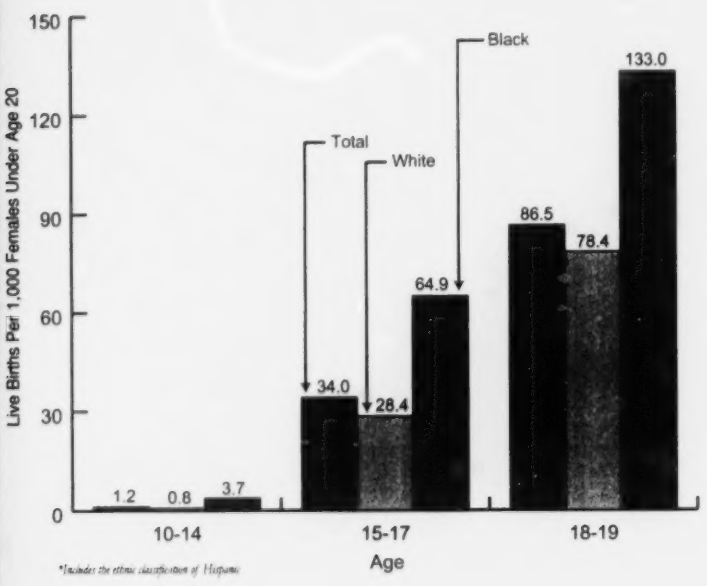
In 1996, there were 502,725 live births among women younger than 20 years of age.

In 1995, a total of 1,210,883 legal abortions were reported to the CDC, 20% of them (242,176) to women under the age of 20. The number of reported abortions among females under age 20 has decreased steadily from 1980 to 1995. The number of births among young women also declined, but at a slower rate, over the same period. However, because not all states require reporting of the age of women obtaining legal abortions, complete data on abortions among adolescents are unavailable.

Researchers consistently find four broad factors, school failure, early behavior problems, poverty, and family problems/family dysfunction, that predict sexual intercourse at an early age, adolescent pregnancy, and nonmarital childbearing: .

LIVE BIRTHS AMONG ADOLESCENTS, BY AGE AND RACE OF MOTHER: 1996

Source (II.11): National Center for Health Statistics



*Includes the ethnic classification of Hispanic

ADOLESCENT CHILDBEARING

In 1996, the live birth rate per 1,000 adolescent females was 1.2 for ages 10–14, 34.0 for ages 15–17, and 86.5 for those 18–19 years old. The rates in 1996 represent an overall decrease of 12% between 1991 and 1996.

In 1996, there were 346,509 live births among white females ages 15–19 and 131,059 births among black teenagers. The birth rates were 48.1, 91.7, and 101.6 for white, black, and Hispanic teenagers respectively. Although the birth rates for black teenagers remains relatively high in comparison to the rate for white teens, the largest decline in birth rates by race between 1991 and 1996 was among black teens. The overall rate of adolescent childbearing among black teens 15–19 years fell 21% to 91.7 per 1,000, the lowest rate ever recorded. The birth rate among Hispanic teens fell the least, 4.8%, leaving Hispanic teenagers with the highest adolescent birth rate in the three groups.

SEXUALLY TRANSMITTED DISEASES

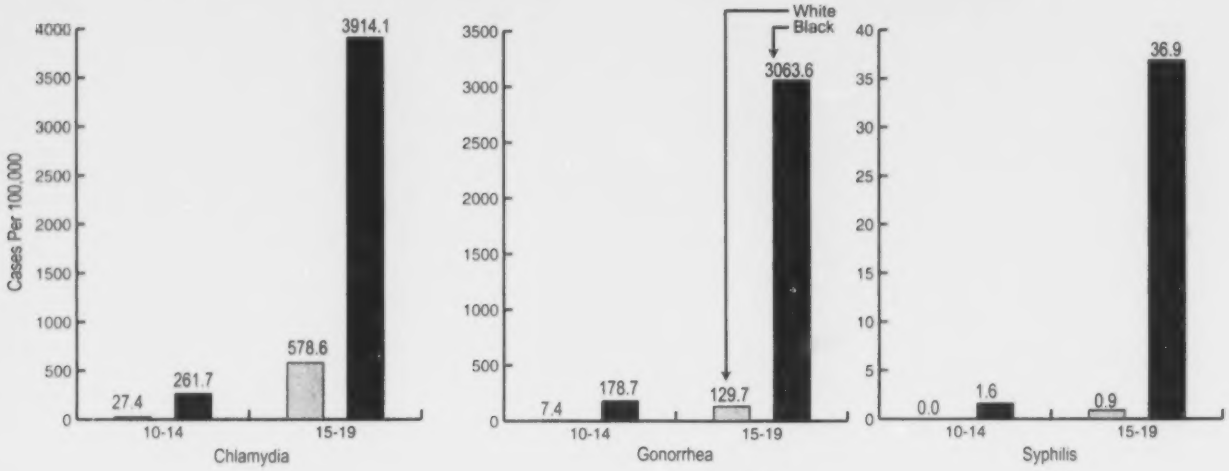
Rates of reportable sexually transmitted diseases (STDs) are particularly high among adolescents (ages 15–19) and young adults (ages 20–24). In these age groups, reported rates of chlamydia, gonorrhea, and syphilis are much higher among black non-Hispanic youth than white non-Hispanics.

The most common STD in adolescents and young adults in 1996 was chlamydia, a bacterial infection, with 1,133 cases per 100,000 teens 15–19, followed by gonorrhea, with 571 cases per 100,000. Syphilis is much rarer in teens, with only 6.4 cases per 100,000 reported in 1996.

Although these conditions are treatable with antibiotics, STDs can have serious health consequences. Active infections can increase the likelihood of contracting HIV, and untreated STDs can lead to pelvic inflammatory disease and infertility in women.

RATES OF SEXUALLY TRANSMITTED DISEASES PER 100,000 ADOLESCENTS BY AGE AND RACE: 1996

Source (II.12): Centers for Disease Control and Prevention



ADOLESCENT AIDS

As of December 31, 1997, 3,379 cases of AIDS had been reported in adolescents aged 13–19 years. This total includes 376 newly reported cases in 1997.

Whites comprised 32% of the AIDS cases among adolescents. Of these, 61% were exposed to HIV primarily through receipt of clotting factor for hemophilia/coagulation disorder or as a result of blood transfusions (however, only six percent of newly-reported cases in 1997 involved this source of transmission). Nineteen percent of whites aged 13–19 years were exposed to HIV through male-to-male sexual contact.

Forty-seven percent of adolescent AIDS cases were among non-Hispanic blacks. Twenty-five percent of these cases were exposed to HIV through male-to-male sexual contact and 33% were exposed through heterosexual contact.

Notes:

1 On January 1, 1993, the AIDS case definition for adults and adolescents aged 13 years and older was expanded to include HIV-infected persons with CD4 counts of less than or equal to 200 cells/uL, or a CD4 percentage of less than or equal to 14, and persons diagnosed with pulmonary tuberculosis, recurrent pneumonia, and invasive cervical cancer.

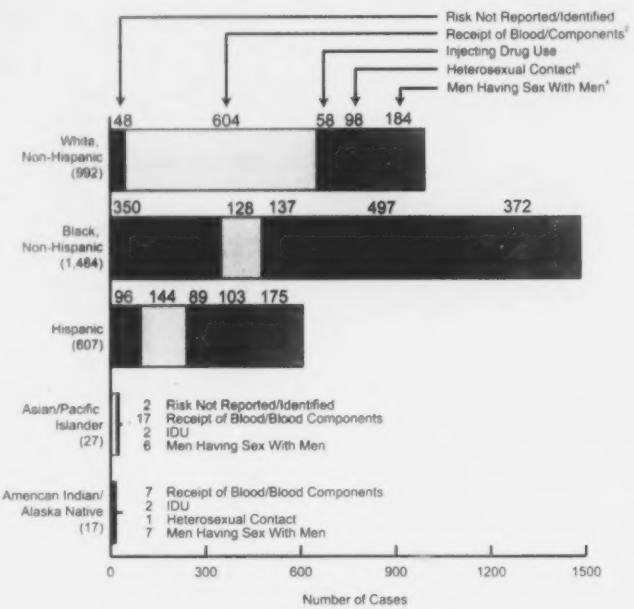
2 Receipt of Blood/Blood components:
- Received clotting factor for hemophilia coagulation disorder
- Received blood transfusions, blood components, or tissue

3 Heterosexual contact includes sex with: an injecting drug user; a person with hemophilia; a transfusion recipient infected with HIV; an HIV-infected person, risk not specific; a bisexual male (females only).

4 The category "Men who have sex with Men" includes men who have sex with men and inject drugs.

ADOLESCENT AIDS CASES, BY RACE/ETHNICITY AND EXPOSURE CATEGORY FOR AGES 13–19: 1981–1997

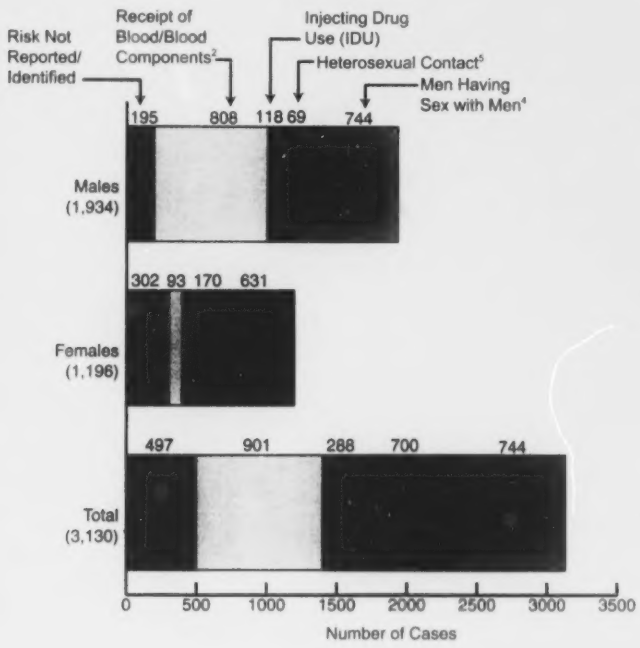
Source (II.13): Centers for Disease Control and Prevention



Note: Race is unknown for 3 persons in this age group; therefore, a total of 3,127 cases are represented in the graph.

ADOLESCENT AIDS CASES BY GENDER AND EXPOSURE CATEGORY FOR AGES 13–19: 1981–1997

Source (II.13): Centers for Disease Control and Prevention



ADOLESCENT AIDS

Males comprised 62% of the 3,130 AIDS cases among adolescents aged 13–19 years. These young men were exposed to HIV primarily through receipt of clotting factor for hemophilia/coagulation disorder or as a result of blood transfusions. Thirty-four percent of males aged 13–19 years with AIDS were exposed to HIV through sexual contact with other males.

Thirty-eight percent of adolescent AIDS cases were among females. Of those, 53% acquired HIV infection through heterosexual contact. Twenty percent had sex partners who were injecting drug users, while 14% were injecting drug users themselves.

Notes:

1 On January 1, 1993, the AIDS case definition for adults and adolescents aged 13 years and older was expanded to include HIV-infected persons with CD4 counts of less than or equal to 200 cells/uL or a CD4 percentage of less than or equal to 14, and persons diagnosed with pulmonary tuberculosis, recurrent pneumonia, and invasive cervical cancer.

2 Receipt of Blood/Blood components:
Received clotting factor for hemophilia coagulation disorder
Received blood transfusions, blood components, or tissue

3 Heterosexual contact includes sex with: an injecting drug user; a person with hemophilia; a transfusion recipient infected with HIV; an HIV infected person, risk not specific; a bisexual male (females only).

4 The category "Men who have sex with Men" includes men who have sex with men and inject drugs.

YOUNG ADULT AIDS

As of December 31, 1997, 22,953 cases of AIDS were reported in young adults aged 20–24 years. This total includes 1,855 newly reported cases in 1997. The number of newly reported cases decreased by nearly 15% from 1996 to 1997.

Across all racial/ethnic groups, men who have sex with men is the major exposure category associated with AIDS cases in young adults. Young adult women (26% of known AIDS cases in this age group) are exposed to HIV primarily through injecting drug use (28%) or through sex with an injecting drug user (23%).

Notes:

1 On January 1, 1993, the AIDS case definition for adults and adolescents aged 13 years and older was expanded to include HIV-infected persons with CD4 counts of less than or equal to 200 cells/uL, or a CD4 percentage of less than or equal to 14, and persons diagnosed with pulmonary tuberculosis, recurrent pneumonia, and invasive cervical cancer.

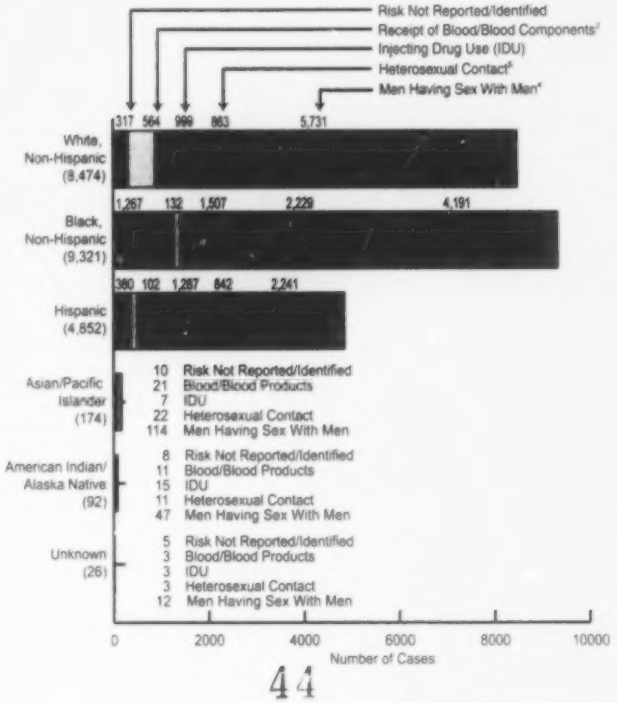
2 Receipt of Blood/Blood components:
Received clotting factor for hemophilia coagulation disorder
Received blood transfusions, blood components, or tissue

3 Heterosexual contact includes sex with: an injecting drug user; a person with hemophilia; a transfusion recipient infected with HIV; an HIV-infected person, risk not specific; a bisexual male (females only).

4 The category "Men who have sex with Men" includes men who have sex with men and inject drugs.

YOUNG ADULT AIDS CASES BY RACE/ETHNICITY AND EXPOSURE CATEGORY FOR AGES 20–24: 1981–1997

Source (IL13): Centers for Disease Control and Prevention



SUBSTANCE ABUSE

Trends in Thirty-Day Prevalence

The Substance Abuse and Mental Health Administration's 1997 National Household Survey on drug abuse shows an increase since 1996 in the use of illicit drugs including marijuana, cocaine, inhalants, heroin, and prescription drugs used non-medically among adolescents age 12-17. This increase is primarily attributable to an increase in the use of marijuana. Overall, 11.4 percent of teens surveyed reported using any illicit drug in the past month, compared to 9.0 percent in 1996.

The proportion of adolescents reporting using marijuana in the past month increased from 7.1 percent in 1996 to 9.4 percent in 1997. This increase represents a reverse in the trend seen since 1995; however, rates of marijuana use are still substantially lower than the rate reported in 1979, 14.2 percent.

No significant change was seen in the reported use of inhalants, hallucinogens, cocaine, or heroin. The percentage of teens reporting using alcohol in the past month, including the percentage who reported binge drinking, also remained statistically unchanged.

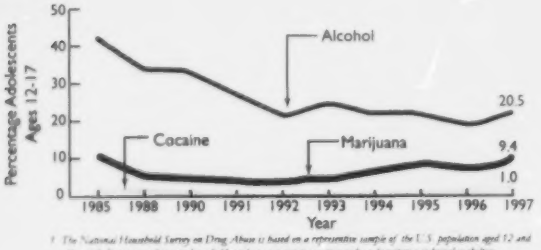
Perception of Risk and Access to Drugs

In 1997, 30.9 percent of teens perceived marijuana as risky, compared to 32.6 percent in 1996. Moreover, 3,900 adolescents ages 12-17 tried heroin for the first time in 1996 (an increase from 2,200 in 1995), and there was no change in perceived risk of cocaine among adolescents ages 12- 17 between 1996 and 1997.

More than half of the adolescents surveyed reported that marijuana was easy to obtain in 1997, and about one fifth reported that heroin was easy to obtain. Approximately fifteen percent of respondents reported being approached by someone selling drugs in the month prior to the survey.

LONG-TERM TRENDS IN THIRTY-DAY PREVALENCE OF USE OF VARIOUS TYPES OF DRUGS AMONG ADOLESCENTS AGES 12–17: 1985–1996

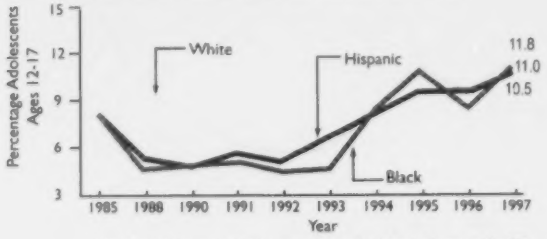
Source (II.14): National Household Survey on Drug Abuse, SAMHSA



1 The National Household Survey on Drug Abuse is based on a representative sample of the U.S. population aged 12 and older, including persons living in households and in some group quarters such as dormitories or homeless shelters.

LONG-TERM TRENDS IN THIRTY-DAY PREVALENCE OF USE OF ANY ILLICIT DRUG AMONG ADOLESCENTS AGES 12–17, BY RACE/ETHNICITY: 1985–1996

Source (II.14): National Household Survey on Drug Abuse, SAMHSA



2 Illicit drugs include marijuana or hashish, cocaine (including crack), inhalants, hallucinogens including PCP and LSD), heroin, or any prescription-type psychotherapeutic used non-medically.

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CIGARETTE SMOKING

The University of Michigan's Institute for Social Research found that, although cigarette smoking among youth in most age and demographic groups did not change significantly between 1996 and 1997, rates of smoking among teenagers have increased significantly between 1991 and 1997. Thirty-seven percent of high school seniors reported that they had smoked cigarettes in the 30 days prior to the survey, a 7 percent increase from 1996.

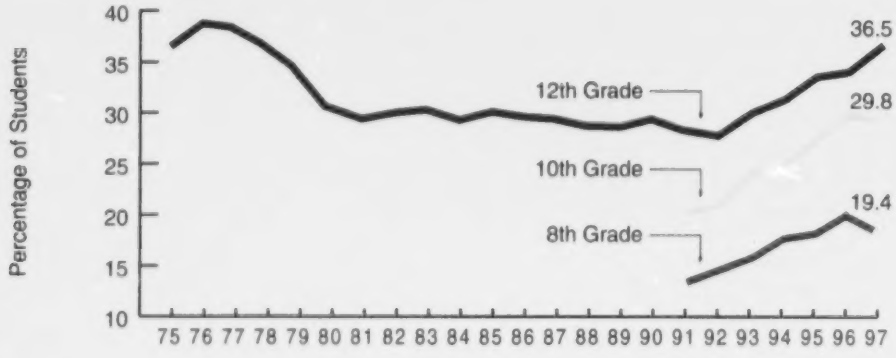
Smoking among adolescents will have severe, lifelong consequences for this generation, because a large proportion of those who initiate smoking in adolescence will continue to smoke for the rest of their lives.

Over the past eight years, substantial increases in smoking have occurred in virtually every sociodemographic group; among boys and girls, among those bound for college and those not, among respondents in all regions of the country and in rural and urban areas, among socioeconomic levels, and among whites, blacks, and Hispanics. The rate of smoking among 8th- and 10th-grade girls increased 50% over this period, and the percentage of black 8th- and 10th-graders who smoked doubled.

There are, however, some subgroup differences in smoking rates: respondents with no future college plans were more likely to smoke than those who had such plans; 12th grade students were most likely to smoke; and African American youth remain substantially less likely to smoke than white youth.

LONG-TERM TRENDS IN THIRTY-DAY PREVALENCE OF CIGARETTE SMOKING FOR 8TH-, 10TH-, AND 12TH-GRADERS: 1976–1997

Source (II.15): The Monitoring the Future Study, University of Michigan



OVERWEIGHT

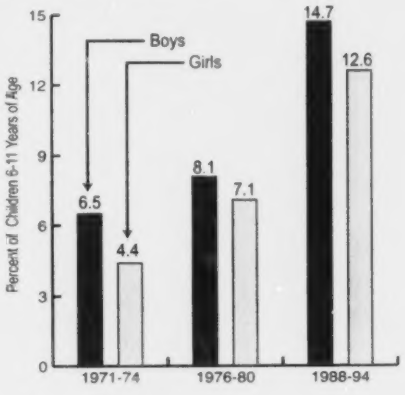
Results of the third National Health and Nutrition Examination Survey (NHANES III: 1988–1994) indicate that 13.6% of children ages 6 to 11 and 11.5% of adolescents ages 12 to 17 are overweight. The percentage of overweight children and adolescents has increased significantly over the past two decades. In 1974, 6.5% of boys and 4.4% of girls ages 6–11 were overweight. By 1994, those percentages had more than doubled for both sexes, to 14.7% of boys and 12.6% of girls in this age group. A similar trend is present in adolescents ages 12–17, with 5.3% of boys and 7.2% of girls overweight in 1974 and 12.4% of boys ages 12–17 and 10.7% of girls overweight in 1994.

The greatest concern about the increase of overweight in children is that overweight children are at high risk of becoming overweight adults; overweight in adulthood is associated with increased risk for morbidity and mortality and chronic medical conditions, such as coronary heart disease, hypertension, diabetes mellitus, gallbladder disease, respiratory disease, some cancers, and arthritis.

The 1995 Youth Risk Behavior Surveillance System Survey (YRBSS) revealed that over 25% of 9th through 12th grade students thought that they were overweight, and over 41% were attempting weight loss. Female students were more than twice as likely as male students to be attempting weight loss (60% versus 24%), as were white and Hispanic students as opposed to black students. Nearly one third of all students had dieted either to lose weight or to keep from gaining weight during the 30 days preceding the survey. Over 50% of students had exercised either to lose weight or to keep from gaining weight.

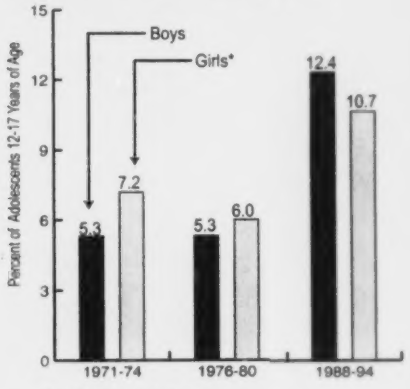
PREVALENCE OF OVERWEIGHT AMONG CHILDREN BY SEX: 1971–1994

Source (II.16): National Center for Health Statistics



PREVALENCE OF OVERWEIGHT AMONG ADOLESCENTS BY SEX: 1971–1994

Source (II.16): National Center for Health Statistics



*Note: Data on girls exclude those who are pregnant.

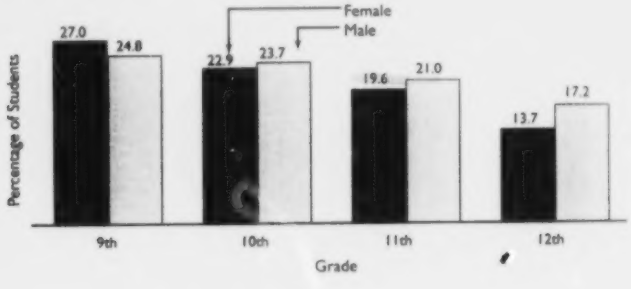
PHYSICAL ACTIVITY

Results of the 1995 Youth Risk Behavior Surveillance System Survey show that nearly two thirds of students participate regularly in vigorous physical activity and more than one fifth regularly participate in moderate physical activity. Furthermore, 50% of the students do regular strengthening exercises. Nationwide, nearly 60% of students were enrolled in a physical education class, but students in 9th grade were significantly more likely to be enrolled than students in 11th and 12th grades.

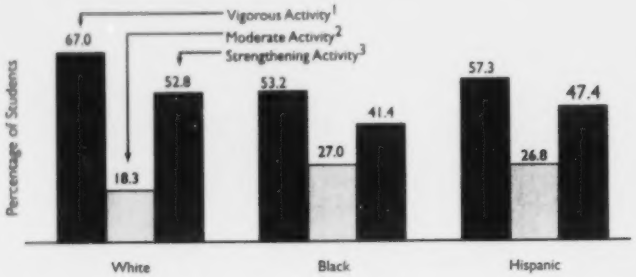
Diet and physical activity are the two primary behavioral factors believed to be associated with becoming overweight. In July 1996, Audrey F. Manley, M.D., M.P.H., the acting Surgeon General, released *Physical Activity and Health: A Report of the Surgeon General.* The report outlined the significant health benefits of regular, moderate physical activity. One of the report's major conclusions is that moderate activity helps to combat the risk of developing various diseases and chronic conditions.

1 Activities that caused sweating and hard breathing for at least 20 minutes >3 of the preceding 7 days.
2 Walked or bicycled for at least 30 minutes on >5 of the 7 days preceding the survey.
3 Such as push-ups, sit-ups, or weight lifting on> of the 7 days preceding the survey.

PERCENTAGE OF HIGH SCHOOL STUDENTS WHO PARTICIPATED IN MODERATE PHYSICAL ACTIVITY, BY GRADE: 1995
Source (II.13): Centers for Disease Control and Prevention



PERCENTAGE OF HIGH SCHOOL STUDENTS WHO PARTICIPATED IN VIGOROUS, MODERATE, OR STRENGTHENING PHYSICAL ACTIVITY, BY RACE: 1995
Source (II.13): Centers for Disease Control and Prevention



HEALTH SERVICES AND UTILIZATION

The availability of, and access to, quality health care directly affect the health of mothers and children, especially those at high risk due to chronic medical conditions or low socio-economic status. As more mothers and children become enrolled in Medicaid managed care, monitoring quality assurance has become, and will continue to be, increasingly important.

New Federal legislation includes provisions to expanded health insurance coverage to the estimated 10 million uninsured children in the U.S. An estimated 3 million of those 10 million children are eligible for Medicaid but are not enrolled. Outreach and consumer education will therefore be key components of the expansion of health insurance coverage for children.

The following section presents data on the utilization of health services within the maternal and child population. The most current data are summarized by source of payment, type of care, and place of service delivery. Data are presented by age, ethnicity, and income.

HEALTH CARE FINANCING

A 1997 report from the Employee Benefit Research Institute indicated that 14.8%, or 10.6 million children younger than 18 years of age, had no insurance coverage in 1996.

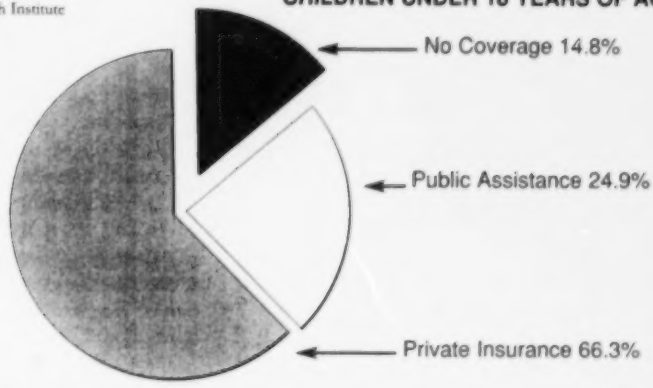
Of those children with insurance, 24.9% were publicly insured, primarily through Medicaid, and 66.3% were covered by private insurance. Most privately insured children (89%) received insurance through their parents' employer, but such coverage, when available, was increasingly expensive and required parental copayments.

Of children younger than 18 whose families lived in poverty, 63.4% were publicly insured and 18.8% had private coverage. However, 24% of children in poverty had no health coverage in 1996. Approximately 23% of children who were eligible for Medicaid remained uninsured. In 1996, an estimated 87% of uninsured children lived in families that had at least one parent who worked part-time or full-time, for all or part of the year.

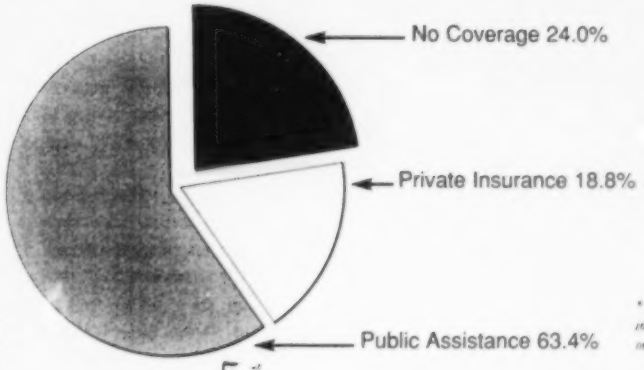
HEALTH INSURANCE COVERAGE: 1996

Source (III.1): Employee Benefit Research Institute

CHILDREN UNDER 18 YEARS OF AGE*



CHILDREN UNDER 18 YEARS OF AGE IN POVERTY*



** Details may add to more than 100% because individuals may receive coverage from more than one source.*

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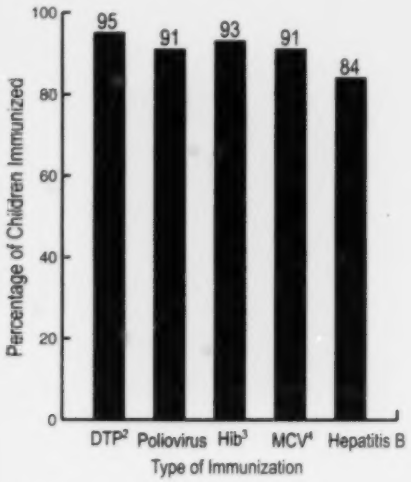
VACCINATION COVERAGE LEVELS AMONG CHILDREN AGED 19–35 MONTHS BY SELECTED VACCINES: 1997*

Source (III.2): Centers for Disease Control and Prevention



1. *Data are from January through December 1997.*
2. *DTP: Diphtheria and Tetanus toxoids and pertussis vaccine, ≥ 3 doses.*
3. *Hib: Haemophilus influenzae type b ≥ 3 doses.*
4. *Includes any measles-containing vaccine, ≥ 1 dose.*

VACCINATION COVERAGE LEVELS

The Year 2000 objective for the complete series of routinely recommended childhood vaccinations is immunization of at least 90% of two-year-olds with the full series of vaccines. Data released from CDC's 1997 National Immunization Survey revealed the highest immunization coverage ever recorded. In fact, all of the Childhood Immunization Initiative goals for 1996 were either met or exceeded. The greatest progress was seen in the rate of hepatitis B vaccination among children aged 19–35 months, which showed a 24% increase, from 68% to 84% between 1995 and 1997. The number of reported cases of rubella, poliomyelitis, pertussis, mumps, measles, hepatitis B, and *H. influenzae* decreased significantly between January 1996 and December 1997.

However, approximately 1 million children still need one or more of the recommended doses of a series vaccine to be fully protected. Coverage in state and urban areas varies, and therefore has not reached the national coverage level in some states and cities.

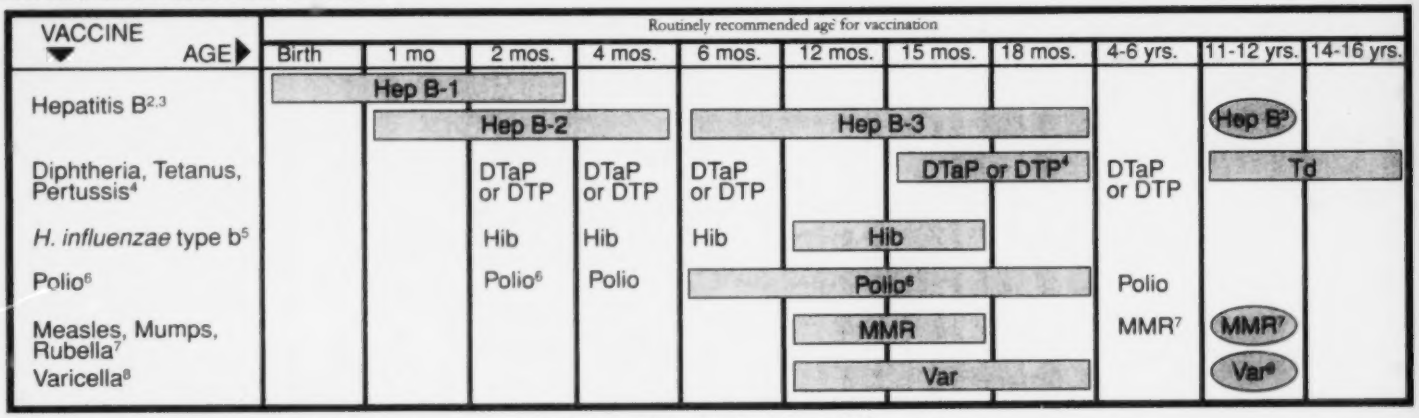
In January 1998, CDC published an updated childhood immunization schedule (see facing page). CDC has also been disseminating a revised polio Vaccine Information Statement. There are two kinds of polio vaccine: Inactivated (IPV), given as a shot, and Oral (OPV). Since it was licensed in 1963, OPV has been used primarily in place of IPV. However, a vaccine schedule using a sequential combination of the two is now recommended: 2 shots of IPV followed by 2 doses of OPV. Furthermore, OPV alone is contraindicated for children with certain existing health conditions.

An additional vaccination recommendation was issued by CDC in early 1996: a new FDA-approved varicella (chicken pox) vaccine. By December 1997, approximately 26% of children aged 19-35 months had received this vaccine.

The recent licensure of combination and single antigen vaccines will further challenge the vaccine delivery system. To maintain high coverage levels among children in the population, additional components of the system need to be developed. These include: 1) linkages between each child and an accountable primary care provider; 2) computerized vaccination registries including both public and private providers; 3) means for ensuring financial access to vaccines; and 4) mechanisms for educating parents about the importance of vaccines and educating providers about changes in recommendations.

RECOMMENDED CHILDHOOD IMMUNIZATION SCHEDULE, UNITED STATES, JANUARY–DECEMBER 1998

Source (III.3): Centers for Disease Control and Prevention



Shaded bar indicates acceptable age range; oval indicates vaccines to be assessed and administered during the early adolescent visit if necessary.

[1] *This schedule indicates the recommended age for routine administration of currently licensed childhood vaccines; vaccines are listed under the ages for which they are routinely recommended. Catch-up immunization should be done during any visits when feasible. Some combination vaccines are available and may be used whenever administration of all components of the vaccine is indicated. Providers should consult the manufacturers' package inserts for detailed recommendations.*

[2] ***Infants born to hepatitis B surface antigen (HbsAg)-negative mothers*** *should receive 2.5ug of Merck vaccine (Recombivax HB) or 10ug of SmithKline Beecham (SB) vaccine (Engerix-B). The second dose should be administered at least one month after the first dose. The third dose should be administered at least 2 months after the second but not before 6 months of age.*

Infants born to HbsAG-positive mothers *should receive .5 ml hepatitis B immune globulin (HBIG) within 12 hours of birth, and either 5ug of Merck vaccine (Recombivax HB) or 10ug of SB vaccine (Engerix-B) at a separate site. The second dose is recommended at age 1–2 months and the third dose at age 6 months.*

Infants born to mothers whose HbsAG status is unknown *should receive either 5ug of Merck vaccine (Recombivax HB) or 10ug of SB vaccine (Engerix-B) within 12 hours of birth. The second dose is recommended at age 1 mo and the 3rd dose at age 6 mos. Blood should be drawn at the time of delivery to determine the mother's HbsAG status; if it is positive, the infant should receive HBIG as soon as possible (no later than age 1 week). The dosage and timing of subsequent vaccine doses should be based upon the mother's HbsAG status.*

[3] *Children and adolescents who have not been vaccinated against hepatitis B in infancy may begin the series during any visit. Those who have not previously received 3 doses of hepatitis B vaccine should initiate or complete the series during the routine visit to a health care provider at age 11–12 years, and unvaccinated older adolescents should be vaccinated whenever possible. The 2nd dose should be administered at least 1 mo after the 1st dose, and the 3rd dose should be administered at least 4 mos after the 1st dose, and at least 2 mos after the 2nd dose.*

[4] *Diptheria and tetanus toxoids and acelluler pertussis vaccine (DtaP) is the preferred vaccine for all doses in the vaccination series, including completion of the series in children who have received one or more doses of whole-cell diptheria and tetanus toxoids and pertussis vaccine (DTP). Whole-cell DTP is an acceptable alternative to DtaP. The 4th dose of DtaP or DTP may be administered as early as 12 mos, provided 6 mos has elapsed since the 3rd dose and the child is unlikely to return at age 15–18 mos. Tetanus and diptheria toxoids, absorbed, for adult use (TP), is recommended at 11–12 years if at least 5 years have elapsed since the last dose of DTP, DtaP, or diptheria and tetanus toxoids, absorbed, for pediatric use (DT). Subsequent routine boosters are recommended every 10 years.*

[5] *Three* H. Influenzae *type b (Hib) conjugate vaccines are licensed for infant use. If Haemophilus b conjugate vaccine (meningococcal protein conjugate) (PRP-OMP) (PedvaxHIB [Merck]) is administered at aget 2 mos and 4 mos, a dose at age 6 mos is not required.*

6 Two poliovirus vaccines are currently licensed and distributed in the United States; inactivated poliovirus vaccine (IPV) and oral poliovirus vaccine (OPV). The following schedules are all acceptable to the ACIP, AAP, and AAFP. Parents and providers may choose among these options. 1) 2 doses of IPV followed by 2 doses of OPV; 2) 4 doses of IPV; or 3) 4 doses of OPV. ACIP recommends 2 doses of IPV at 2 and 4 mos followed by a dose of OPV at age 12-18 mos and at age 4-6 years. IPV is the only poliovirus vaccine recommended for immunocompromised persons and their household contacts.

7 The second dose of MMR is recommended routinely at age 4–6 years but may be administered during any visit, provided at least one month has elapsed since receipt of the first dose aand that both doses are administered beginning at or after age 12 mos. Those who have not previously received the second dose should complete the schedule no later than the routine visit to a health care provider at age 11–12 years.

8 Susceptible children may receive varicella vaccine (Var) at any visit after the first birthday, and those who lack a reliable history of chickenpox should be vaccinated during the routine visit to a health-care provider at age 11–12 years. Susceptible children aged _>13 years should receive 2 doses at least 1 mo apart.

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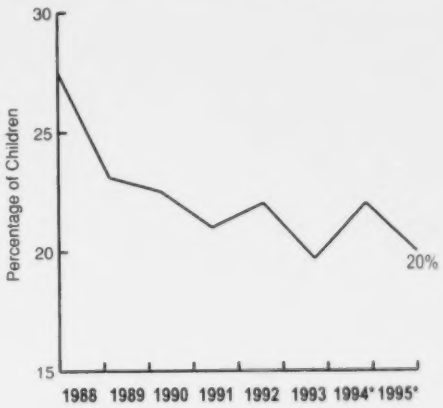
DENTAL SCREENING

Access to oral health care is a significant problem for low-income children. Vulnerable children are more likely than children in general to have dental problems, including extensive tooth decay, pain, and infection. These problems can lead to eating, learning, and speech problems and are the cause of 52 million lost school hours each year.

Although dental problems can be prevented with regular screening and preventive services, these services are not always available to those children who most need them. In 1995, fewer than one in five children eligible for dental services under the Medicaid Early and Preventive Screening, Diagnosis, and Treatment (EPSDT) program received a preventive dental service, and this percentage is declining.

PERCENTAGE OF CHILDREN RECEIVING AN EPSDT PREVENTIVE DENTAL SERVICE: 1988–1995

Source (III.4): National Maternal and Child Oral Health Resource Center



*Preliminary estimate

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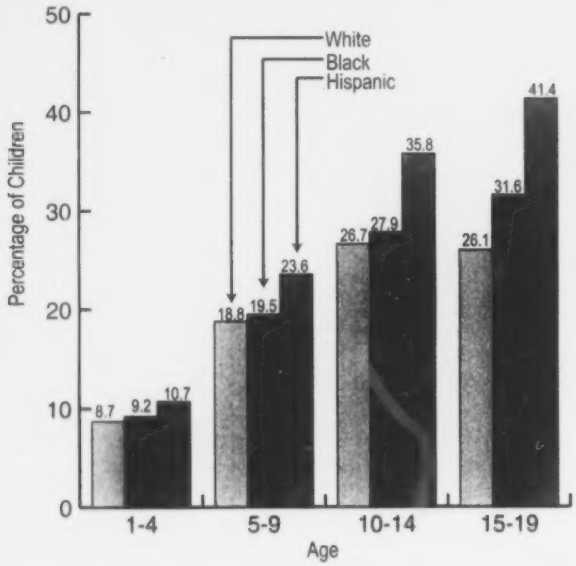
PERCENTAGE OF CHILDREN WITH NO PHYSICIAN VISITS IN THE PAST YEAR, BY AGE AND RACE/ETHNICITY: 1995

Source (III.5): National Center for Health Statistics



PHYSICIAN VISITS

In 1995, approximately 20.7 percent of children under age 20, or 14.6 million children, had not been seen by a physician in the past year. In all age groups, a higher percentage of black and Hispanic children than white children had not been seen by a physician in the past year.

During 1995, 8.7 percent of white, 9.2 percent of black, and 10.7 percent of Hispanic-origin children ages 1–4 were not seen by a physician.

PLACE OF PHYSICIAN CONTACT

Among children who saw a physician in the past year, children younger than 5 years old averaged more physician contacts than school-aged children.

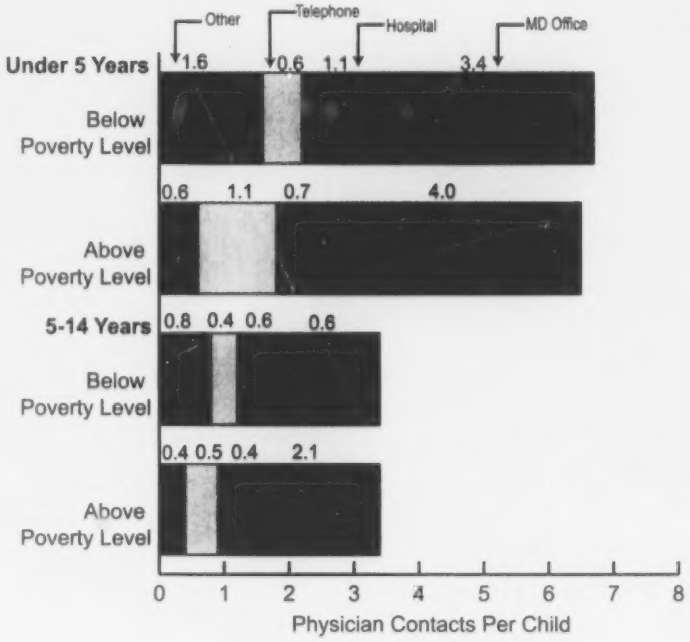
Children whose family income was above the poverty level used more physician services than children in poverty.

Children in poverty were more likely to see physicians in hospitals and places other than physicians' offices than children above poverty.

From 1994 to 1995, the number of physician contacts per child in a physician's office, for children in poverty, increased for children under 5 and decreased slightly for children aged 5–14.

PLACE OF PHYSICIAN CONTACT BY AGE AND POVERTY STATUS: 1995

Source (III.5): National Center for Health Statistics



SERVICE USE BY CHILDREN WITH CHRONIC CONDITIONS

Physician Use

In 1995, children who were limited in their activities* had three times as many physician contacts as children without chronic conditions.** The number of physician contacts per person for children without activity limitations remained stable from 1994 to 1995, while it increased for children ages 5 and above with limitations and decreased for activity-limited children under age 5.

Hospital Use

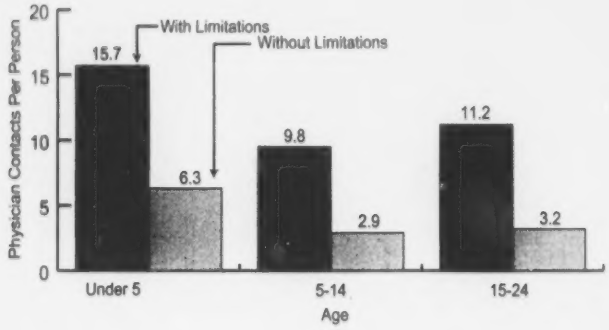
Children with chronic conditions spend about 10 times as many days in the hospital as children without activity limitations.

**Limitation of activity is defined as the inability to participate in ordinary play for children less than 5 years old, or the inability to attend school for children 5 to 17 years old.*

***Chronic conditions persist for more than three months. Conditions that are considered chronic regardless of their time of onset include diabetes and heart conditions.*

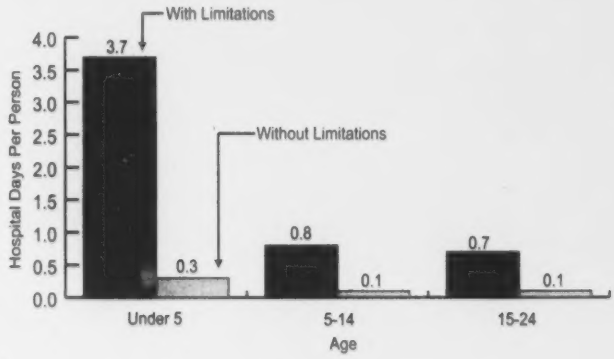
PHYSICIAN UTILIZATION BY CHILDREN WITH CHRONIC ACTIVITY LIMITATIONS, BY AGE: 1995

Source (III.5): National Center for Health Statistics



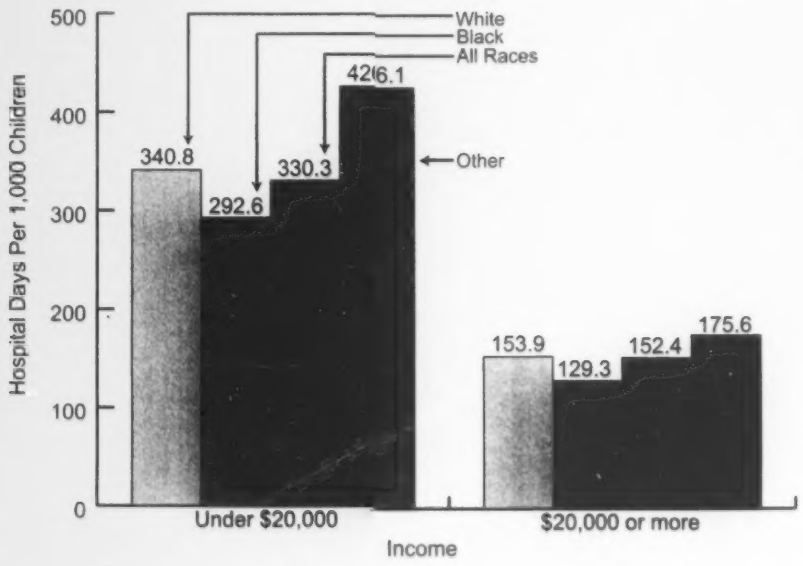
HOSPITAL UTILIZATION BY CHILDREN WITH CHRONIC ACTIVITY LIMITATIONS, BY AGE: 1995 (EXCLUDING DELIVERIES)

Source (III.5): National Center for Health Statistics



HOSPITAL UTILIZATION BY INCOME AND RACE: 1995

Source (III.5): National Center for Health Statistics

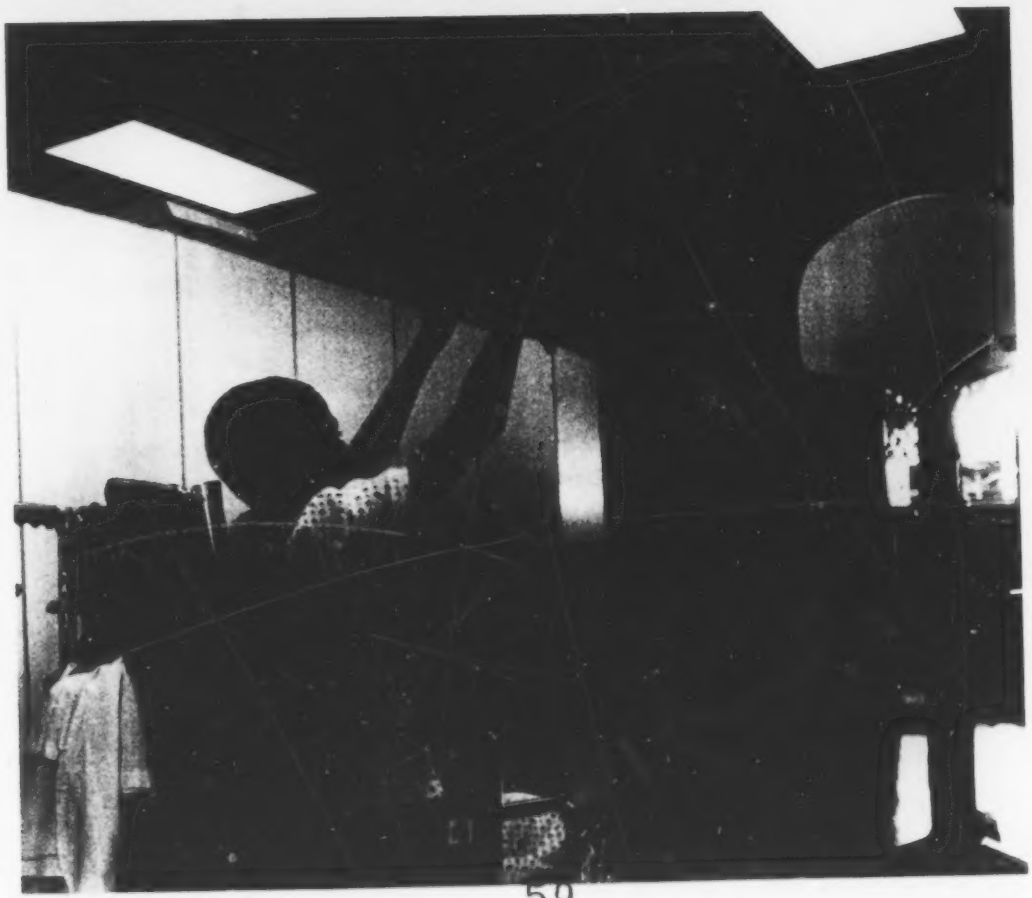


HOSPITAL UTILIZATION

In 1995, children younger than age 18 in families with incomes less than $20,000 averaged 2.2 times as many hospital days per 1,000 children as children in higher-income families.

For black children, hospital days per 1,000 children in both income groups declined substantially from 1994 to 1995. For white children in higher-income families and children of other races in both income groups, rates of hospital use increased.

*Other includes:
Indian, Eskimo, Aleut, Chinese, Filipino, Hawaiian, Korean, Vietnamese, Japanese, Asian Indian, Samoan, Guamanian, Other Asia Pacific Islanders, Other Race, Multiple Race, Unknown



PRENATAL CARE

Early Prenatal Care

The proportion of mothers beginning prenatal care in the first trimester of pregnancy increased for the seventh consecutive year, rising from 81.3% in 1995 to 81.9% in 1996.

In 1996, 84% of white mothers, as compared with 71% of black mothers, received early prenatal care. This represents a substantial racial disparity.

Women younger than 20 are less likely than older women to receive early prenatal care.

Late or No Prenatal Care

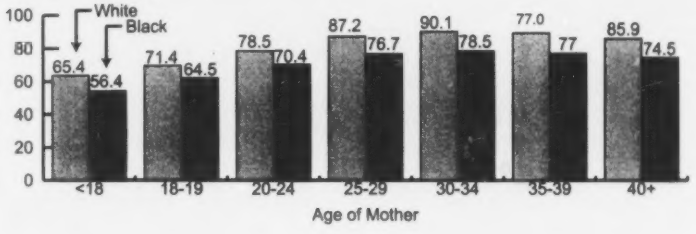
Every year from 1983 to 1991, 6% of all of infants were born to mothers who initiated care during the third trimester or received no prenatal care. However, that figure decreased to 4% in 1996.

Regardless of age, black women are less likely to receive prenatal care than are white women.

Risk factors for not receiving prenatal care include being less than 18 years of age, unmarried status, low educational attainment, and minority group status.

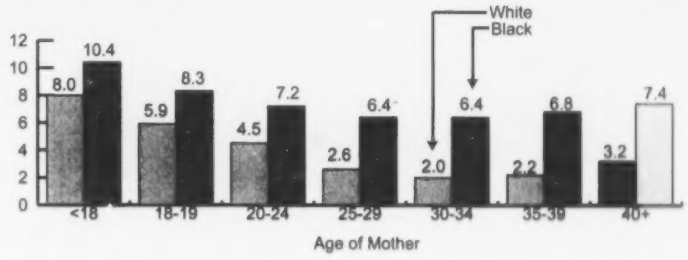
PERCENTAGE OF BIRTHS TO WOMEN WITH EARLY PRENATAL CARE, BY AGE AND RACE OF MOTHER: 1995

Source (III.6): National Center for Health Statistics



PERCENTAGE OF BIRTHS TO WOMEN WITH LATE OR NO PRENATAL CARE, BY AGE AND RACE OF MOTHER: 1995

Source (III.6): National Center for Health Statistics



61

STATE DATA

While the indicators presented in the previous sections of this book are representative of the U.S. as a whole, the next section presents individual health status indicators, data on infant, neonatal, and perinatal mortality, low birth weight, early prenatal care, births to women under 18, health care financing for children, and Medicaid enrollment and expenditures.

The following pages reveal stark disparities in the health status of children living in different states. In 1996, the national infant mortality rate (deaths per 1,000 live births) was 7.3. Among the 50 states, Massachusetts had the lowest rate (4.4), while the District of Columbia has the highest rate (14.9).

Women living in Alabama, Louisiana, Mississippi, South Carolina, and the District of Columbia were more likely to give birth to low birth weight babies (less than 2,500 grams or 5.5 pounds) than women in other regions of the country. These same states, along with Georgia, Maine, Arkansas, and North Carolina, also had the highest rates of infant mortality. High levels of poverty within these states (more than 20% of children living below poverty) may be associated with these health status trends.

Poverty in the U.S. has continued to rise steadily during the last three decades. Title XIX of the Social Security Act (Medicaid) assures that children living in poverty receive adequate health care services. In 1996, the District of Columbia had the greatest proportion of children with health care financed via Medicaid (38.2%) whereas Indiana had the smallest proportion (8%). The national average was 20.6%. Poverty affects living conditions and access to health care and nutrition, all of which contribute to health status.

The challenge to health care providers and policy-makers continues to be eliminating the disparities among states while improving the health status of children throughout the entire nation.

INFANT, PERINATAL, AND NEONATAL MORTALITY RATES, BY RACE OF MOTHER AND STATE, 1996

Source (IV.1): National Center for Health Statistics

State	Infant Mortality[1]			Perinatal Mortality[2]			Neonatal Mortality[3]		
	All***	White	Black	All***	White	Black	All***	White	Black
UNITED STATES	**7.3**	**6.1**	**14.7**	**7.4**	**6.4**	**13.3**	**4.8**	**4.0**	**9.6**
ALABAMA	10.5	8.2	15.5	10.4	7.9	15.8	6.9	5.1	10.6
ALASKA	7.2	5.8	*	5.2	4.7	*	3.5	3.2	*
ARIZONA	7.6	7.1	20.5	6.9	6.6	16.1	5.1	4.9	12.8
ARKANSAS	9.3	8.1	14.0	8.5	7.8	11.5	5.6	5.0	8.1
CALIFORNIA	5.9	5.5	13.9	6.6	6.2	12.0	3.8	3.6	8.2
COLORADO	6.6	6.4	14.7	7.1	6.9	12.7	4.4	4.2	9.7
CONNECTICUT	6.4	5.3	14.9	7.2	6.5	13.5	4.6	3.8	10.7
DELAWARE	7.6	6.0	12.7	7.3	6.6	10.1	5.1	3.8	9.3
DC	14.9	*	17.6	13.7	*	16.4	10.0	*	12.0
FLORIDA	7.5	5.8	13.3	7.5	6.1	12.6	4.7	3.7	8.6
GEORGIA	9.2	6.3	14.9	9.0	6.5	13.8	6.2	4.0	10.5
HAWAII	5.8	4.4	*	5.5	5.0	*	3.6	*	*
IDAHO	7.4	7.4	*	7.5	7.6	*	4.4	4.4	*
ILLINOIS	8.6	6.4	18.2	8.4	6.9	14.8	5.7	4.4	11.1
INDIANA	8.7	7.5	18.4	8.8	8.4	13.3	5.6	5.0	10.6
IOWA	7.0	6.5	22.9	6.7	6.5	*	4.9	4.7	*
KANSAS	8.3	7.2	23.1	7.7	7.0	17.7	5.5	4.7	15.9
KENTUCKY	7.5	6.9	13.6	7.6	7.2	11.9	4.9	4.5	8.6
LOUISIANA	9.0	6.5	12.8	8.6	6.6	11.5	5.6	4.0	8.0
MAINE	4.4	4.4	*	5.7	5.6	*	3.4	3.4	*
MARYLAND	8.5	5.7	14.5	8.6	5.9	14.0	5.8	3.5	10.7
MASSACHUSETTS	5.0	4.8	8.8	6.1	6.0	8.5	3.6	3.6	4.7
MICHIGAN	8.1	5.9	17.6	7.0	5.7	12.8	5.3	3.9	11.6
MINNESOTA	5.9	5.1	14.5	6.1	5.5	14.4	3.6	3.2	9.6
MISSISSIPPI	11.0	8.0	14.6	10.8	8.0	14.1	7.2	4.9	9.9
MISSOURI	7.6	6.2	15.7	7.0	6.3	11.8	4.8	4.0	10.3
MONTANA	7.0	6.8	*	6.5	6.3	*	4.4	4.2	*
NEBRASKA	8.7	8.4	*	8.8	8.6	*	5.8	5.8	*
NEVADA	6.2	5.4	13.7	5.3	4.9	*	3.4	2.7	*
NEW HAMPSHIRE	5.0	5.0	*	5.3	5.2	*	3.5	3.6	*
NEW JERSEY	6.9	5.3	14.9	7.2	6.0	13.3	4.8	3.9	6.6
NEW MEXICO	6.2	6.1	*	5.5	5.5	*	3.9	4.0	*
NEW YORK	7.0	5.7	12.4	7.9	6.9	12.9	4.8	4.0	8.1
NORTH CAROLINA	9.2	7.1	9.6	9.6	7.7	15.2	6.1	4.7	10.3
NORTH DAKOTA	5.3	5.0	*	6.3	6.1	*	3.7	3.6	*
OHIO	7.7	6.3	16.2	7.8	6.7	14.5	5.1	4.1	10.8
OKLAHOMA	8.5	7.7	17.6	8.0	7.9	11.6	5.0	4.6	11.2
OREGON	5.6	5.3	*	6.1	6.0	*	3.3	3.1	*
PENNSYLVANIA	7.8	6.4	16.9	8.2	7.1	14.4	5.4	4.5	11.3
RHODE ISLAND	5.2	5.1	*	6.6	6.9	*	4.0	3.9	*
SOUTH CAROLINA	8.4	5.6	13.7	9.8	6.2	16.6	5.7	3.5	9.9
SOUTH DAKOTA	5.7	4.5	*	6.3	5.0	*	3.0	2.3	*
TENNESSEE	8.5	6.7	15.4	8.1	6.6	13.8	5.2	4.2	9.3
TEXAS	6.3	5.7	11.7	6.0	5.5	10.1	3.8	3.4	7.1
UTAH	6.0	5.9	*	5.8	5.8	*	4.0	3.9	*
VERMONT	7.1	6.9	*	7.4	7.5	*	4.6	4.5	*
VIRGINIA	7.7	6.1	13.8	7.6	5.9	13.8	5.3	4.0	10.0
WASHINGTON	6.0	5.6	15.7	6.2	5.9	14.0	3.7	3.6	9.0
WEST VIRGINIA	7.4	6.9	*	7.4	7.2	*	4.9	4.5	*
WISCONSIN	7.3	6.1	18.8	7.7	6.8	14.7	4.7	4.0	11.4
WYOMING	6.4	6.2	*	8.2	8.0	*	4.0	4.0	*

** Figure does not meet standards of reliability or precision*
*** Quantity zero*
**** Includes races other than white or black.*

1 Rates are deaths less than one year per 1,000 live births in specified group.
2 Rates are fetal deaths ≥ 28 weeks and infant deaths < 7 days per 1,000 live births.
3 Rates are deaths under 28 days per 1,000 live births in specified group.

PERCENTAGE OF INFANTS BORN AT LOW BIRTH WEIGHT, WOMEN RECEIVING FIRST TRIMESTER PRENATAL CARE, AND BIRTHS TO WOMEN UNDER 18, BY RACE OF MOTHER AND STATE: 1996

Source (IV.2): Report of Final Natality Statistics

State	Percentage Low Birth Weight			Percentage with Early Prenatal Care			Percentage of Births to Women < 18			
	All***	White	Black	All***	White	Black	All***	White	Black	Hispanic
UNITED STATES†	**7.4**	**6.3**	**13.0**	**81.9**	**84.0**	**71.4**	**5.1**	**4.2**	**10.3**	**7.3**
ALABAMA	9.3	7.2	13.6	81.6	87.8	68.8	7.5	5.1	12.6	5.8
ALASKA	5.5	5.0	12.1	80.8	83.2	81.8	3.9	2.7	5.9	4.2
ARIZONA	6.7	6.5	12.4	73.7	74.8	69.6	6.0	5.8	9.8	9.0
ARKANSAS	8.5	7.0	13.6	74.8	78.7	61.0	7.4	5.7	13.6	6.5
CALIFORNIA	6.1	5.5	11.8	80.6	80.4	78.8	4.7	4.8	7.6	6.6
COLORADO	8.8	8.5	15.0	81.4	81.9	75.5	4.6	4.4	8.0	9.6
CONNECTICUT	7.2	6.4	12.9	88.2	89.7	77.1	3.4	2.8	8.5	10.3
DELAWARE	8.5	6.7	14.1	83.6	87.0	72.8	6.1	3.8	14.0	7.1
DC	14.3	7.2	16.7	64.6	77.4	60.0	7.7	2.9	9.5	6.4
FLORIDA	7.9	6.6	12.2	83.3	86.5	72.3	5.4	4.0	10.4	5.1
GEORGIA	8.5	6.4	12.7	85.2	89.0	78.0	6.7	4.7	10.9	5.8
HAWAII	7.3	4.9	8.6	84.2	89.3	86.4	3.6	1.3	*	7.3
IDAHO	5.8	5.7	*	78.9	79.2	75.7	4.6	4.6	*	8.3
ILLINOIS	8.0	6.3	14.5	81.5	84.7	68.8	5.1	3.5	12.1	6.6
INDIANA	7.6	6.9	13.9	80.4	82.2	64.7	5.3	4.5	12.2	7.6
IOWA	6.4	6.0	14.7	87.1	87.7	75.0	3.9	3.6	12.6	8.8
KANSAS	6.9	6.4	13.4	85.5	86.4	76.4	4.6	4.1	11.0	9.0
KENTUCKY	7.9	7.4	12.7	84.7	85.8	74.3	6.3	5.7	12.9	5.4
LOUISIANA	9.9	6.9	14.3	81.1	88.7	70.4	7.6	4.6	12.1	5.2
MAINE	5.9	5.8	*	89.9	90.1	85.5	3.2	3.2	*	*
MARYLAND	8.6	6.3	13.4	88.3	92.4	78.5	4.3	2.4	8.4	4.3
MASSACHUSETTS	6.4	6.0	10.4	83.7	85.6	70.6	2.8	2.5	5.9	9.9
MICHIGAN	7.7	6.4	13.6	84.2	87.0	71.5	4.7	3.5	10.1	8.6
MINNESOTA	5.8	5.4	12.0	83.5	86.0	64.5	3.2	2.5	10.8	8.4
MISSISSIPPI	9.9	7.3	12.9	78.6	88.0	68.0	9.3	5.0	14.2	*
MISSOURI	7.5	6.5	12.8	85.5	87.9	72.2	5.2	4.1	11.6	7.6
MONTANA	6.4	6.2	*	82.7	84.4	81.6	4.3	3.5	*	12.8
NEBRASKA	6.3	6.0	10.7	84.5	85.4	73.2	3.8	3.2	13.0	7.9
NEVADA	7.5	6.8	14.0	77.6	78.5	67.4	5.1	4.8	10.4	7.1
NEW HAMPSHIRE	4.8	4.7	*	89.1	89.3	76.4	2.5	2.5	*	*
NEW JERSEY	7.7	6.4	13.1	81.8	85.5	65.5	3.2	2.2	8.5	6.1
NEW MEXICO	7.5	7.5	13.5	69.7	71.9	60.9	7.3	7.3	9.0	10.0
NEW YORK	7.7	6.5	11.9	79.1	82.6	68.4	3.5	2.9	6.6	6.1
NORTH CAROLINA	8.7	6.8	13.9	83.5	88.1	71.8	6.0	4.2	11.0	5.9
NORTH DAKOTA	5.7	5.7	*	84.7	86.3	78.7	3.0	2.3	*	*
OHIO	7.5	6.5	13.2	85.4	87.6	72.5	4.9	3.8	11.4	9.0
OKLAHOMA	7.4	6.8	13.1	78.7	81.1	67.1	6.4	5.4	11.6	8.0
OREGON	5.3	5.2	11.2	79.9	80.3	76.6	4.8	4.6	12.3	8.5
PENNSYLVANIA	7.5	6.5	14.1	84.2	87.1	67.1	4.2	3.1	11.1	11.8
RHODE ISLAND	6.9	6.5	12.0	89.6	90.8	78.6	4.2	3.5	9.0	8.9
SOUTH CAROLINA	9.2	7.0	13.2	79.4	86.2	67.1	6.8	4.5	11.3	4.7
SOUTH DAKOTA	5.8	5.8	*	81.7	85.5	63.9	4.0	3.0	*	*
TENNESSEE	8.8	7.3	14.2	83.3	86.7	71.5	6.4	4.9	12.2	5.1
TEXAS	7.2	6.5	12.4	78.1	78.4	74.0	6.8	6.4	10.7	8.8
UTAH	6.6	6.6	12.0	83.8	84.7	64.5	3.6	3.5	7.4	8.6
VERMONT	6.2	6.2	*	87.4	87.5	*	2.8	2.8	*	*
VIRGINIA	7.7	6.3	12.2	84.5	88.4	72.1	4.1	2.9	8.7	4.5
WASHINGTON	5.6	5.3	10.8	83.2	84.1	76.7	4.1	3.9	7.5	8.0
WEST VIRGINIA	8.0	7.8	12.4	81.9	82.5	65.9	5.8	5.6	10.8	*
WISCONSIN	6.3	5.6	12.7	84.1	87.0	66.2	4.0	2.6	14.3	8.4
WYOMING	8.4	8.3	*	81.9	82.5	64.6	5.1	4.8	*	10.3

** figure does not meet standards of reliability or precision*
*** data not available*
† excludes data for Puerto Rico, Virgin Islands, and Guam
**** includes races other than white and black*

MEDICAID RECIPIENTS, EXPENDITURES, AND REPORTED EPSDT UTILIZATION FOR CHILDREN UNDER AGE 21, FY 1996

Source (IV.3): American Academy of Pediatrics

State	Medicaid Recipients	Medicaid Expenditures per Recipient Ages 1–5	Medicaid Expenditures per Recipient Ages 16–20	% Medicaid Recipients who Used EPSDT Services
UNITED STATES	**18,257,442**	**$1,085**	**$1,549**	**32.1**
ALABAMA	305,903	$702	$1,041	45.4
ALASKA	41,759	1,423	3,077	10.8
ARIZONA	NA	NA	NA	NA
ARKANSAS	190,871	$1,712	$2,020	43.6
CALIFORNIA	2,551,074	$769	$959	34.5
COLORADO	145,491	$1,013	$1,732	30.8
CONNECTICUT	150,503	$636	$1,536	21.0
DELAWARE	48,977	$1,643	$2,090	41.2
DC	80,877	$1,846	$2,129	2.8
FLORIDA	870,044	$1,214	$1,161	25.3
GEORGIA	707,077	$1,263	$1,249	NA
HAWAII	2,921	$5,206	$2,467	9.9
IDAHO	73,710	$876	$1,643	26.8
ILLINOIS	814,445	$1,009	$1,786	63.1
INDIANA	317,001	$1,115	$1,460	14.5
IOWA	161,709	$1,136	$2,012	48.1
KANSAS	144,061	$865	$1,654	NA
KENTUCKY	322,741	$1,273	$1,572	13.1
LOUISIANA	456,762	$1,013	$1,524	62.4
MAINE	80,227	$1,480	$2,162	49.2
MARYLAND	179,872	$1,715	$3,105	21.3
MASSACHUSETTS	340,646	$1,310	$1,668	25.7
MICHIGAN	596,727	$964	$1,022	27.7
MINNESOTA	244,529	$1,473	$1,857	14.1
MISSISSIPPI	277,018	$1,101	$1,432	59.8
MISSOURI	338,294	$929	$1,122	36.0
MONTANA	56,053	$1,054	$1,859	28.7
NEBRASKA	117,315	$845	$1,524	30.8
NEVADA	62,171	$1,307	$2,327	46.7
NEW HAMPSHIRE	54,964	$1,204	$2,086	31.6
NEW JERSEY	342,303	$1,305	$1,897	13.6
NEW MEXICO	209,156	$1,105	$1,888	24.2
NEW YORK	1,635,451	$1,887	$2,917	34.7
NORTH CAROLINA	623,139	$1,044	$1,499	61.2
NORTH DAKOTA	30,238	$1,122	$1,928	0.0
OHIO	816,935	$1,057	$1,338	0.0
OKLAHOMA	193,277	$823	$1,794	19.7
OREGON	162,547	$1,652	$2,060	92.2
PENNSYLVANIA	576,877	$1,117	$1,816	40.4
RHODE ISLAND	58,759	$1,214	$1,550	10.0
SOUTH CAROLINA	277,420	$831	$1,764	36.7
SOUTH DAKOTA	46,331	$945	$1,847	44.9
TENNESSEE	628,502	$732	$1,396	0.0
TEXAS	1,636,155	$896	$1,271	46.9
UTAH	92,317	$987	$1,567	0.2
VERMONT	54,226	$667	$1,558	65.1
VIRGINIA	358,825	$869	$1,069	28.9
WASHINGTON	329,480	$662	$743	2.2
WEST VIRGINIA	218,912	$913	$1,553	32.4
WISCONSIN	202,115	$1,076	$1,584	28.5
WYOMING	30,736	$1,190	$1,596	29.9

Note: NA=Not Available.

HEALTH INSURANCE STATUS FOR CHILDREN UNDER AGE 22: 1996

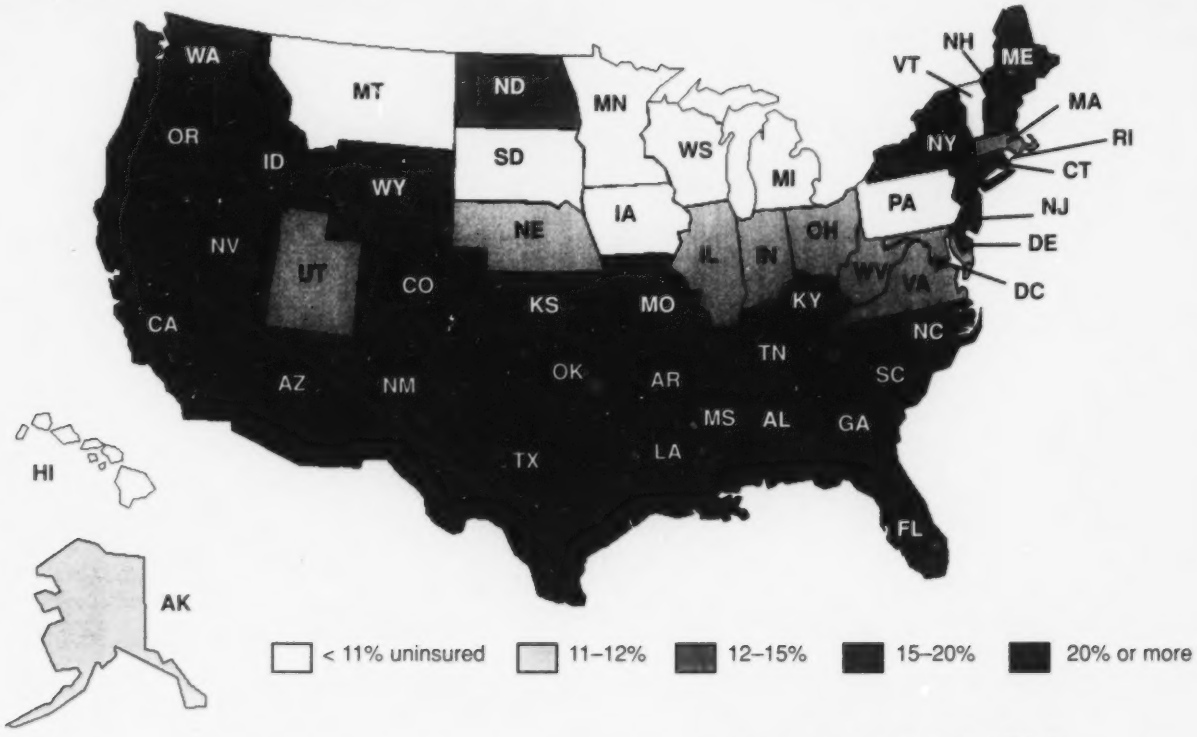
Source (IV.4): American Academy of Pediatrics

State	Percent with Private/Employer-Based Insurance	Percent Enrolled in Medicaid	Percent Uninsured*
UNITED STATES	**62.8**	**20.6**	**16.7**
ALABAMA	65.8	20.4	13.8
ALASKA	61.9	26.2	11.8
ARIZONA	48.1	24.0	27.9
ARKANSAS	55.6	20.6	23.7
CALIFORNIA	55.2	24.6	20.2
COLORADO	70.0	11.2	18.9
CONNECTICUT	68.5	18.4	13.0
DELAWARE	67.7	18.6	13.7
DC	47.8	38.2	14.0
FLORIDA	56.4	22.5	21.1
GEORGIA	59.6	23.2	17.2
HAWAII	67.4	26.0	6.6
IDAHO	65.5	17.5	17.0
ILLINOIS	68.7	20.1	11.1
INDIANA	80.4	8.0	11.6
IOWA	75.7	13.7	10.7
KANSAS	73.8	13.7	12.5
KENTUCKY	57.9	22.2	19.9
LOUISIANA	53.7	21.7	24.5
MAINE	70.0	15.2	14.8
MARYLAND	72.3	16.3	11.4
MASSACHUSETTS	69.1	19.6	11.3
MICHIGAN	70.0	21.5	8.5
MINNESOTA	69.5	20.1	10.4
MISSISSIPPI	55.7	24.4	19.8
MISSOURI	63.3	22.6	14.2
MONTANA	57.8	31.3	10.9
NEBRASKA	70.8	17.4	11.8
NEVADA	64.3	15.5	20.2
NEW HAMPSHIRE	74.7	13.1	12.2
NEW JERSEY	67.0	13.4	19.6
NEW MEXICO	47.6	31.3	21.1
NEW YORK	56.2	27.3	16.5
NORTH CAROLINA	63.9	18.3	17.8
NORTH DAKOTA	75.9	11.9	12.2
OHIO	71.4	16.9	11.7
OKLAHOMA	58.0	21.0	21.0
OREGON	64.1	17.1	18.8
PENNSYLVANIA	74.3	16.9	8.8
RHODE ISLAND	73.7	17.5	8.8
SOUTH CAROLINA	62.4	15.2	22.4
SOUTH DAKOTA	70.4	19.9	9.6
TENNESSEE	49.7	30.5	19.8
TEXAS	53.0	20.0	27.0
UTAH	77.0	11.1	11.9
VERMONT	61.2	30.4	8.4
VIRGINIA	74.1	14.8	11.1
WASHINGTON	65.1	21.1	13.9
WEST VIRGINIA	59.3	29.3	11.4
WISCONSIN	76.4	16.3	7.3
WYOMING	70.7	15.6	13.7

*See map on facing page

PERCENTAGE OF UNINSURED CHILDREN UNDER THE AGE OF 22: 1996

Source (IV.4): American Academy of Pediatrics



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CITY DATA

How does the health of infants and children in America's cities compare to that of children nationwide? This section includes data on infant mortality, low birth weight, and prenatal care for women and children who reside in the Nation's central cities with populations over 100,000.

As the following data indicate, the health status of children living in large U.S. cities is generally inferior to that of children in the Nation as a whole. While the infant mortality rate has decreased in both cities and the Nation, a disparity in rates remains. Higher rates of low birth weight contributed to the 1996 city infant mortality rate of 8.4 deaths per 1,000 live births; the national rate was 7.4. The percentage of pregnant women receiving first trimester prenatal care is lower in cities (78.1%) as compared to the Nation (81.9%). The percentage of women receiving late or no prenatal care is nearly a third higher in cities than in the Nation as a whole (5.3% versus 4.0%).

The challenge for health care providers and special initiatives is to eliminate these disparities by improving the health status of children in the Nation's cities.

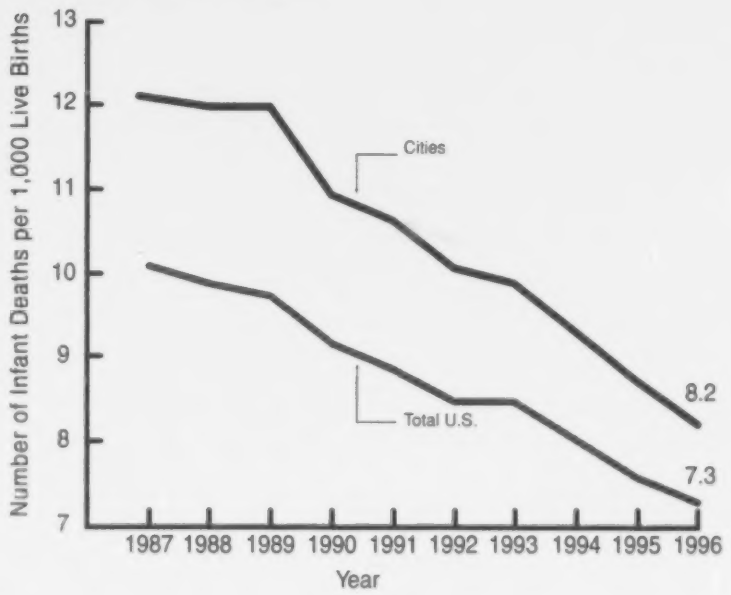
INFANT MORTALITY

In 1996, 9,936 infants born to residents of U.S. cities with populations over 100,000 died in the first year of life. The city infant mortality rate was 8.2 deaths per 1,000 live births, 12% higher than the rate of 7.3 for the nation as a whole. The 1996 rate of 8.2 represents an almost 6% decrease in the 1995 city infant mortality rate of 8.7.

Although the infant mortality rate in cities has routinely been higher than the rate in the nation as a whole, it has steadily declined over the past decade. Between 1987 and 1996, infant mortality in cities declined more than 32%; the decline nationwide in the same period was approximately 28%.

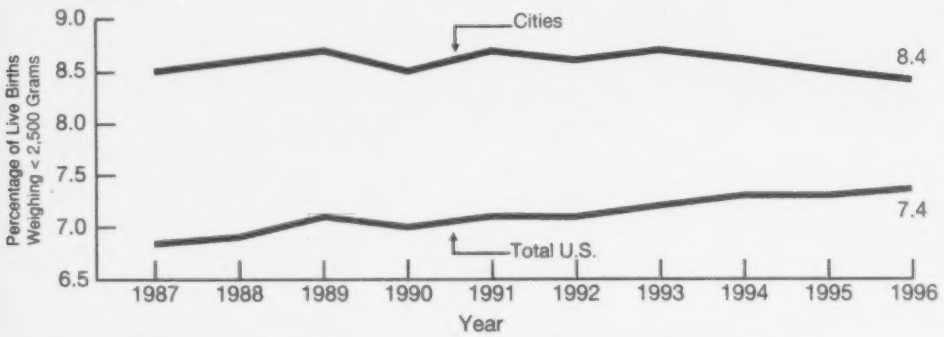
INFANT MORTALITY RATES IN U.S. CITIES WITH POPULATION OVER 100,000: 1987–1996

Source (V.1): National Center for Health Statistics



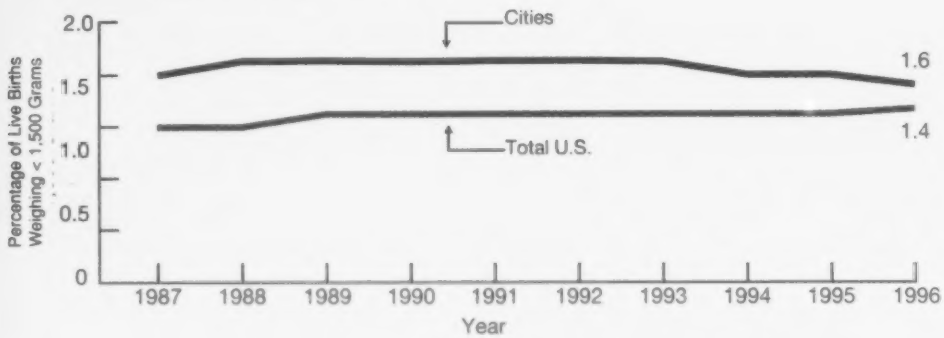
PERCENTAGE OF INFANTS BORN AT LOW BIRTH WEIGHT IN U.S. CITIES WITH POPULATIONS OVER 100,000: 1987–1996

Source (V.1): National Center for Health Statistics



PERCENTAGE OF INFANTS BORN AT VERY LOW BIRTH WEIGHT IN U.S. CITIES WITH POPULATIONS OVER 100,000: 1987–1996

Source (V.1): National Center for Health Statistics



BIRTH WEIGHT

Low Birth Weight

Disorders related to short gestation and low birth weight are the number two cause of neonatal mortality.* In 1996, 101,130 babies (8.4% of all live births) born to residents of U.S. cities with populations over 100,000 were of low birth weight (weighing less than 2,500 grams or 5.5 pounds). The 1996 percentage of city infants with low birth weight was 14% higher than the national percentage of 7.4%.

Very Low Birth Weight

Infants with very low birth weight (less than 1,500 grams or 3 pounds, 5 ounces) are at highest risk for poor health outcomes. In both 1995 and 1996, 1.6% of live births in cities with populations over 100,000 were of very low birth weight. However, it exceeded the national percentage of very low birth weight infants by nearly 14%. The national percentage of very low birth weight infants rose in 1996.

**Congenital anomalies are the leading cause of neonatal mortality.*

PRENATAL CARE

Early Prenatal Care

Women living in U.S. cities with a population of over 100,000 are less likely to begin prenatal care in the first three months of pregnancy than women nationwide. Since 1987, the percentage of pregnant women receiving early prenatal care in cities has averaged 6.7% less per year than the national percentage.

In 1996, 78.1% of pregnant women living in U.S. cities began prenatal care in the first trimester of pregnancy, compared to 81.9% nationwide. The percentage of women receiving prenatal care has increased steadily since 1989 at both the city and national levels. The corollary Healthy People 2000 Objective is to have 90% of pregnant women begin prenatal care in the first trimester.

Late or No Prenatal Care

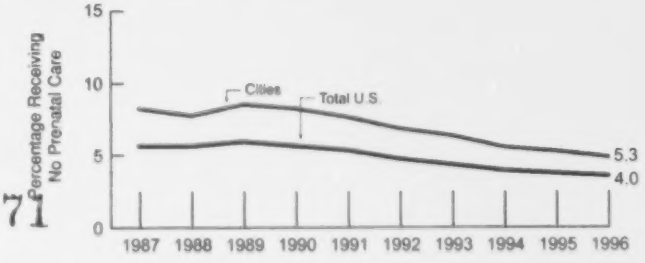
The percentage of pregnant women living in U.S. cities with a population of over 100,000 who began prenatal care in the 3rd trimester or received no prenatal care decreased from 5.7% to 5.3% between 1995 and 1996. However, the percentage of women receiving late or no prenatal care is 33% higher among women living in cities than among the overall U.S. population.

PERCENTAGE OF PREGNANT WOMEN RECEIVING FIRST TRIMESTER PRENATAL CARE IN U.S. CITIES WITH POPULATIONS OVER 100,000: 1987–1996

Source (V.1): National Center for Health Statistics

PERCENTAGE OF PREGNANT WOMEN RECEIVING NO PRENATAL CARE IN U.S. CITIES WITH POPULATIONS OVER 100,000: 1987–1996

Source (V.1): National Center for Health Statistics



PROGRESS TOWARDS HEALTHY PEOPLE 2000 OBJECTIVES FOR THE NATION

Source (VI.1): Public Health Service

CHILD HEALTH USA INDICATOR	CHILD HEALTH USA MEASURE	HP2000 OBJECTIVE		1996 (OR MOST CURRENT) STATISTIC
Adolescent Overweight Prevalence	Percentage of adolescents ages 12 to 17 who are overweight **(page 45)**	1.2	Overweight prevalence of no more than 15% among adolescents ages 12 to 19.	(1994) 11.5% of adolescents ages 12 to 17 overweight
Adolescent Physical Activity	Percentage of high school students who participated in moderate physical activity (30 minutes/day) 5 of the 7 previous days **(page 46)**	1.3	At least 30% of people ages 6 and older engage regularly or daily in light to moderate physical activity for at least 30 minutes/day	(1995) 9th grade: (F) 27.0% (M) 24.8% 10th grade: (F) 22.9% (M) 23.7% 11th grade: (F) 19.6% (M) 21.0% 12th grade: (F) 13.7% (M) 17.2%
Adolescent Smoking	Thirty-day prevalence of cigarette smoking for 8th–12th graders **(page 44)**	3.5	No more than 15% of adolescents become regular smokers by age 20	(1997) 8th grade: 19.4% 10th grade: 29.8% 12th grade: 36.5%
Adolescent Substance Abuse	Thirty-day prevalence of alcohol, marijuana and cocaine use by adolescents ages 12–17 **(page 43)**	4.6	Use in past month by adolescents (ages 12–17) Alcohol 12.6% Marijuana: 3.2% Cocaine 0.6%	Alcohol: 20.5% Marijuana: 9.4% Cocaine: 1.0%
Adolescent Childbearing	Live births per 1,000 female adolescents ages 10–19 **(page 38)**	5.1	No more than 50 *pregnancies* per 1,000 girls ages 15–17	34 *live births* per 1,000 girls ages 15–17

CHILD HEALTH USA INDICATOR	CHILD HEALTH USA MEASURE	HP2000 OBJECTIVE	1996 (OR MOST CURRENT) STATISTIC
Adolescent Sexual Activity	Percentage of students in grades 9–12 who have ever had sexual intercourse **(page 36)**	5.4 No more than 15% by age 15 No more than 40% by age 17	(1995) 9th grade (F) 32.1%; (M) 40.6% 10th grade (F) 46.0%; (M) 50.0% 11th grade (F) 60.2%; M) 57.1% 12th grade (F) 66.0%; (M) 67.1%
Adolescent Sexually Transmitted Diseases	Cases of gonorrhea per 100,000 adolescents (ages 15–19) **(page 39)**	19.1b Per 100,000 adolescents (ages 15–19): Gonorrhea: No more than 375	571 cases per 100,000 adolescents (ages 15–19)
Adolescent Firearm Mortality	Deaths by firearms per 100,000 adolescents (ages 15–19) **(page 35)**	Deaths per 100,000 adolescents (ages 15–19): 6.1 No more than 8.2 suicides 7.3 No more than 12.9 firearm-related deaths	Firearm deaths per 100,000 adolescents (15–19): Homicide 13.3 Suicide 6.1 Unintentional 1.3
Hospitalization	Number of hospital discharges among children, by illness **(page XX)**	6.3 Less than 17% prevalence of mental disorders among children and adolescents 11.1b No more than 225 per 100,000 children aged 14 and younger hospitalized for asthma	4.1 discharges per 100 children 224,000 discharges due to mental disorder (ages 10–21) 485,000 discharges for respiratory disease (ages 1–19)

CHILD HEALTH USA INDICATOR	CHILD HEALTH USA MEASURE	HP2000 OBJECTIVE	1996 (OR MOST CURRENT) STATISTIC
Child Abuse	Cases per 1,000 children under 18 **(page 32)**	7.4 Incidence of maltreatment of children under age 18 of less than 22.6 per 1,000	15 cases per 1,000 children under age 18
		Rate of abuse per 1,000 children under age 18 by type of abuse:	Percentage of total by type of abuse:
		7.4a Physical, less than 4.9	Physical 22%
		7.4b Sexual, less than 12.1	Sexual 12%
		7.4c Emotional, less than 3.0	Emotional 6%
		7.4d Neglect, less than 14.6	Neglect 58%
School Dropout Rates	Percentage of adolescents (ages 16–24) not enrolled/completed high school **(page 16)**	8.2 At least 90% high school completion rate	Dropout rate for ages 16–24: Hispanic 29.4% Black 13.0% White 7.3%
Child Injury Mortality	Injury-related deaths per 100,000 children in specified age group **(page 27)**	7.1a No more than 3.1 homicides among children under 3	Deaths per 100,000 population:
		9.3a No more than 4.4 motor vehicle deaths per 100,000 children under 15	
		9.5a No more than 2.3 deaths due to drowning, fires, and burns: deaths per 100,000 children4 and younger	
		9.6a No more than 3.3 fire-related deaths per 100,000 children 4 and younger	

Ages	1–4	5–14
Homicide	2.7	1.3
Vehicle crashes	5.3	5.2
Drowning	3.0	1.1
Fire-related deaths	2.6	0.8

CHILD HEALTH USA INDICATOR	CHILD HEALTH USA MEASURE	HP2000 OBJECTIVE	1996 (OR MOST CURRENT) STATISTIC
Adolescent Mortality	Leading causes of deaths per 100,000 adolescents (ages 15–19) **(page 34)**	(Age-related objective) No more than 85 deaths per 100,000 adolescents ages 15–24	Deaths per 100,000 adolescents (ages 15–19): 75.8
		9.3b No more than 26.8 deaths by motor vehicle crashes per 100,000 adolescents ages 15–24	Motor vehicle crashes 28.6
Infant Mortality	Infant deaths per 1,000 live births **(page 21)**	14.1 No more than 7 deaths per 1,000 live births	7.3 deaths per 1,000 live births
Postneonatal Mortality	Deaths per 100,000 live births among infants ages 28 days to 11 months **(page 22)**	14.1g No more than 2.5 postneonatal deaths per 1,000 live births	2.5 deaths per 1,000 live births
Neonatal Mortality	Deaths of infants less than 28 days old per 100,000 live births **(page 22)**	14.1 No more than 4.5 deaths per 1,000 live births	4.8 deaths per 1,000 live births
Maternal Mortality	Maternal deaths per 100,000 live births **(page 23)**	14.3 No more than 3.3 deaths per 100,000 live births	7.6 deaths per 100,000 live births
Low Birth Weight	Percentage of live births less than 2.500 grams (5.5 lbs) **(page 18)**	14.5 No more than 5% of live births	7.4% of all live births

CHILD HEALTH USA INDICATOR	CHILD HEALTH USA MEASURE	HP2000 OBJECTIVE		1996 (OR MOST CURRENT) STATISTIC
Infant Feeding	Breastfeeding in hospital and 5–6 months postpartum **(page 24)**	14.9	75% in hospital; 50% at 5–6 months postpartum	(1997) 62.4% in hospital 26% at 5–6 months postpartum 5–6 month postpartum by race: Hispanic: 24.5% White: 28.6% Black: 14.5%
Prenatal Care	Initiation of prenatal care in the first trimester **(page 58)**	14.1	90% of all pregnant women	81.9% of births were to women who received care in the first trimester
Adolescent Condom Use	Percentage of high school students using a condom during last intercourse **(page 36)**	18.4	Condom used during last intercourse: Young women (15–19): 60%; young men (15–19): 75%	(1995) 9th grade 62.9% 10th grade 59.7% 11th grade 52.3% 12th grade 49.5%

CHILD HEALTH USA INDICATOR	CHILD HEALTH USA MEASURE	HP2000 OBJECTIVE	1996 (OR MOST CURRENT) STATISTIC
Vaccination	Coverage levels among children (ages 19–35 months) **(page 50)**	20.11 At least 90% of basic immunization series among children under age 2	(1997) Children (19–35 months) receiving vaccinations: DTP 95% Polio 91% Hib 93% MCV 91% Hep B 84%
Immunization and Infectious Diseases	Number of cases of vaccine-preventable diseases (children under age 5) **(page 30)**	20.1 2000 Target (all ages) Diphtheria 0 Tetanus 0 Polio 0 Measles 0 Mumps 500 Rubella 0 Congenital rubella 0 Pertussis 1000	(1997) children < 5 years Diphtheria 1 Tetanus 0 Polio 1 Measles 54 Mumps 127 Rubella 10 Congenital rubella 6 Pertussis 2480
Physician Visits	Percentage of children with no physician visits in past year **(page 53)**	Population receiving basic preventive services: 21.2a Up to 24 months 90% 21.2b Ages 2–12 80% 21.2c Ages 13–18 50%	Children < 20 years old: 79.3% seen by physician in past year

CHILD HEALTH USA INDICATOR	CHILD HEALTH USA MEASURE	HP2000 OBJECTIVE	1996 (OR MOST CURRENT) STATISTIC
Health Insurance Coverage	Percentage of children under 18 with no insurance coverage **(page 49)**	21.3 95% of population have source of ongoing primary care 21.4 No citizen has financial barrier to receiving preventive services	14.8% of children under 18 uninsured (10.6 million children nationally)
Child Mortality	Deaths due to leading causes in specified age group **(page 26)**	(Age-related objective): No more than 28 deaths per 100,000 children ages 1–14	Deaths per 100,000 children: 26.3 Ages 1–4: 25.6 5–14: 16.3

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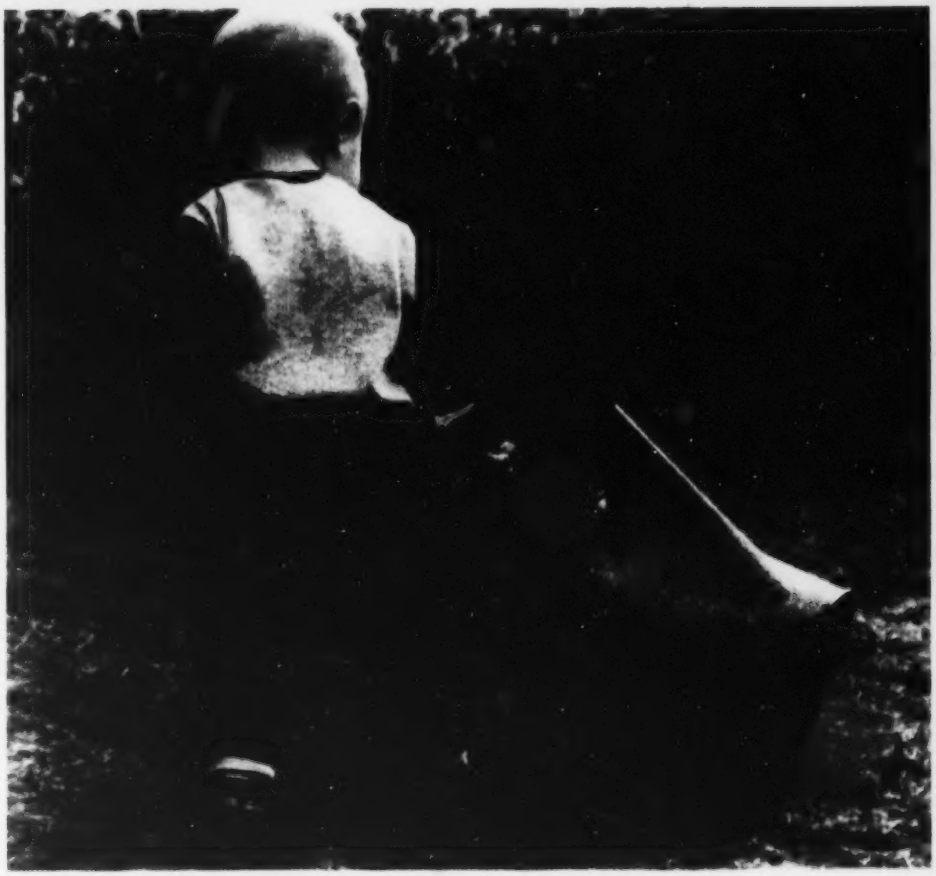
The National Center for Health Statistics, the U.S. Bureau of the Census, the Centers for Disease Control and Prevention, the U.S. Bureau of Labor Statistics, the U.S. Department of Education, the National Center on Child Abuse and Neglect, the University of Michigan Institute for Social Research, the Employee Benefit Research Institute, Abbott Laboratories, and the American Academy of Pediatrics.



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